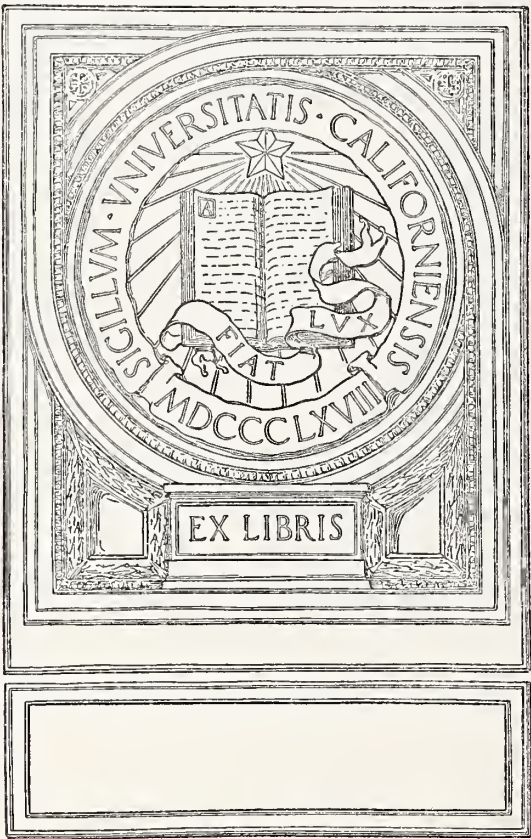




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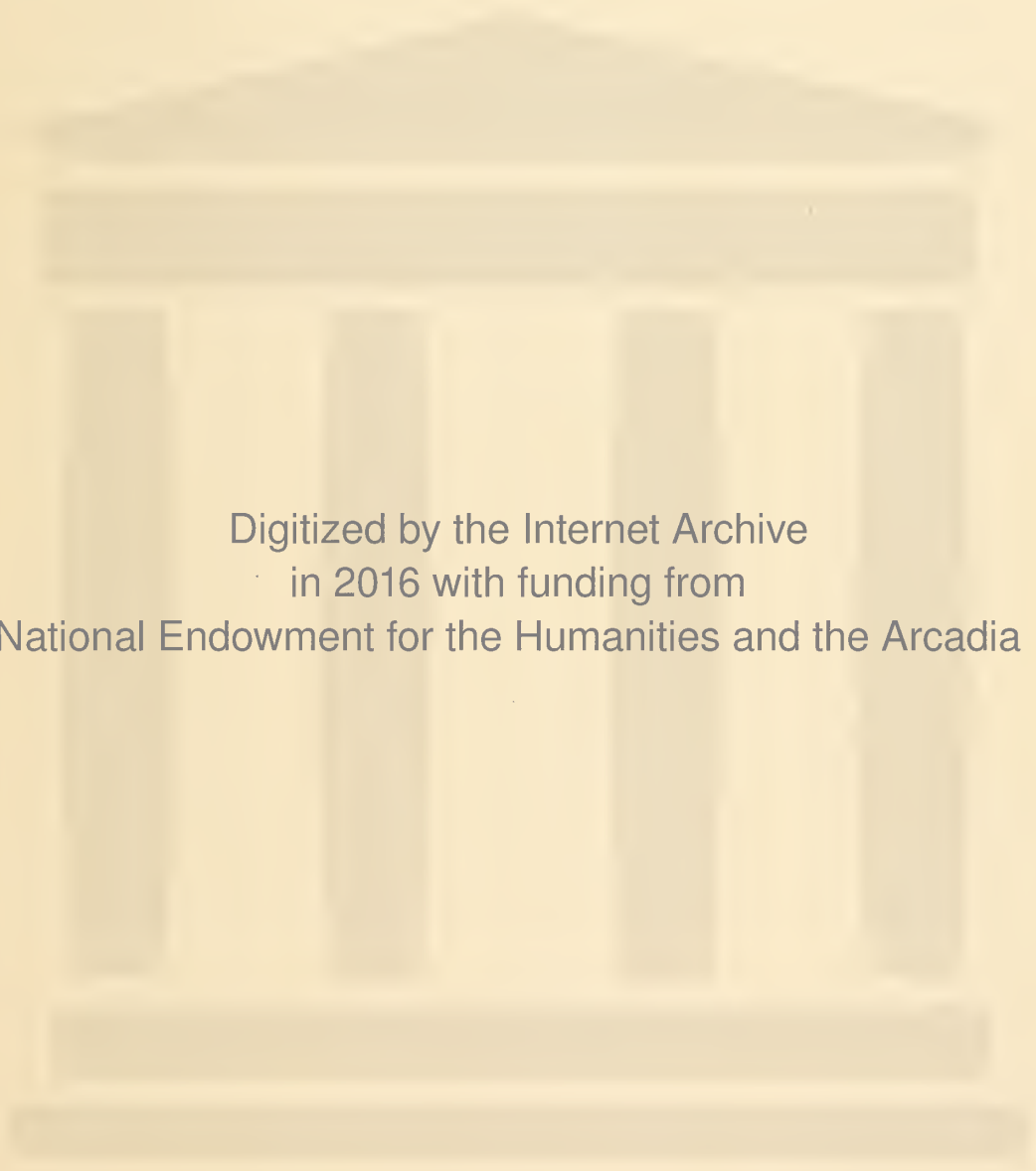
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# The Connecticut State Medical Journal

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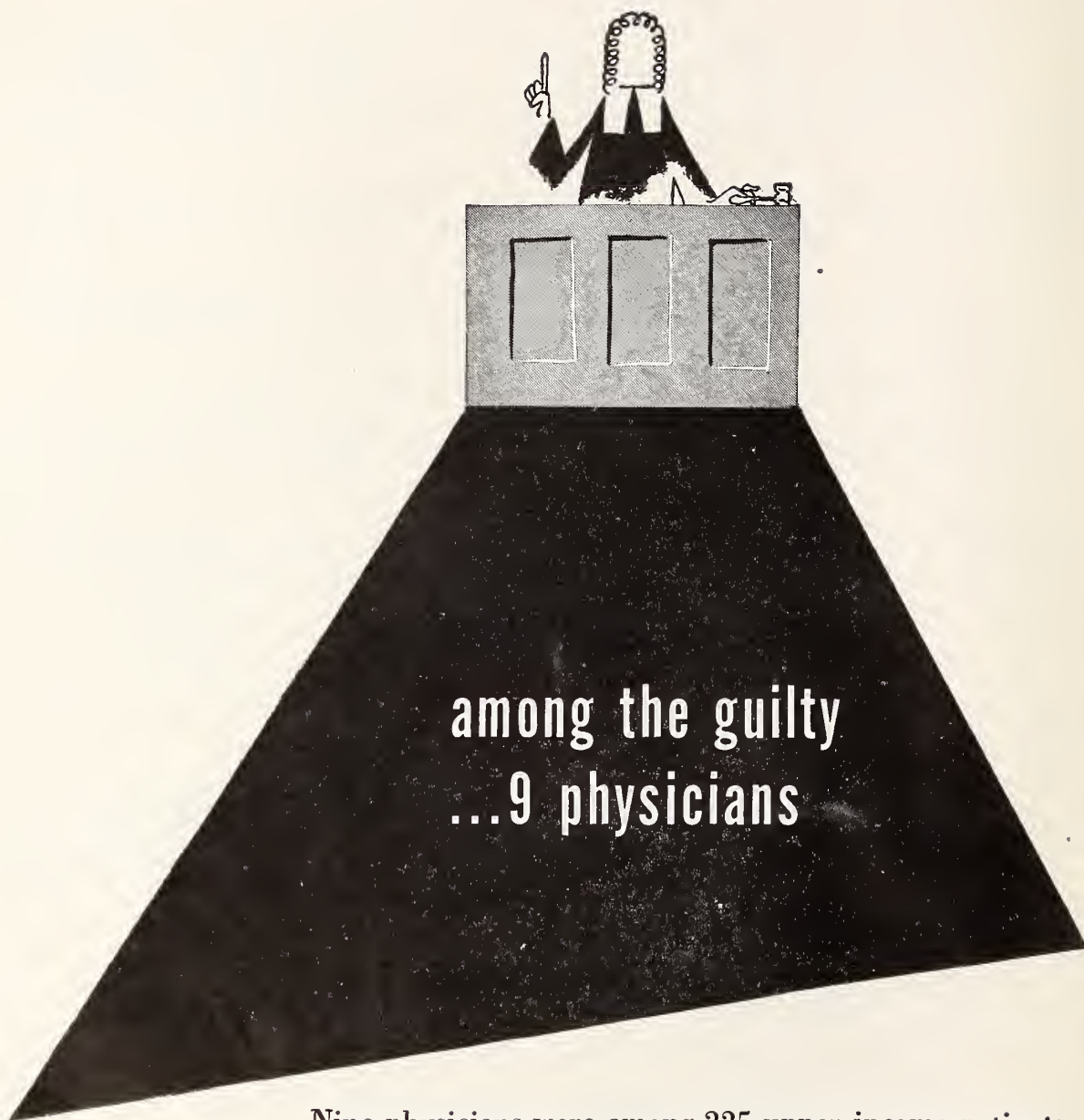
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among the guilty  
...9 physicians

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1. New England J. Med. 228:118 (Jan. 28) 1943.
2. J. A. M. A. 129:613 (Oct. 27) 1945.



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U P J O H N V I T A M I N S





JAMES L. McCONAUGHY, LL.D.

*The*  
CONNECTICUT STATE MEDICAL JOURNAL

VOL. XI

JANUARY, 1947

No.

TO THE PHYSICIANS OF CONNECTICUT:

I am grateful for the opportunity of again expressing, in behalf of the State of Connecticut, our gratitude to Connecticut's doctors for their leadership and devotion during the difficult war years.

All of you were rendering "war service" whether you were actually in uniform or not. Long hours, overwork, no vacations were your lot.

In the years immediately ahead our doctors will be called upon for equally important service. Our people are health conscious as never before. All kinds of new medical programs are being discussed; some involve the Federal Government, some the State Government, some the principal of health insurance. Without passing on the merits or weaknesses of these suggestions, we can surely assert that our people want health more than ever before. Leadership in these efforts must come from our doctors.

1947 will, I am sure, be a busy year for all of you. I also believe it will be a rewarding year, in increased opportunities for leadership by our doctors in better health for all our citizens.

James L. McConaughy,  
Governor of Connecticut



## EARLY EXPERIENCES WITH PENICILLIN THERAPY

SIR HOWARD FLOREY, *Oxford, England*

[Editor's Note: The following remarks were made by Sir Howard Florey previous to the showing of a film at the Twenty-first Clinical Congress on September 11, 1946. They are printed here, not only to present to our readers the ideas of the distinguished Nobel Laureate, but also to preserve a record of an historic event in the annals of Connecticut medicine.]

I should like first of all to thank you very much for your very kind invitation to address you here this morning. I only received the invitation a little while ago, owing to my moving about rather rapidly in recent weeks, and so I have had no time to prepare something as I should like to have done for a meeting of this importance. There is an enormous amount of literature coming out all the time about the antibiotics and I have made one very useful discovery about this which may be of use to some of you; that is I get my wife to read it and then tell me if there is anything I should know about, and in that way I save a great deal of time. But it does mean that I have only a nodding acquaintance with clinical literature and so, as most of you are, I understand, mainly interested in the practice of medicine, I don't feel that I have much to tell you.

What I propose to do this morning is to show you a film which I think has now some historical interest in that it is of some of the first casualties to be treated in the war with penicillin and, curiously enough, I think it is one of the few films that were made on war wounds. First I shall give you a brief explanation of how the film came to be taken.

In 1942, and the beginning of 1943, penicillin was extremely rare. Those of you who use it now with the greatest freedom perhaps would find it difficult to believe how very much we prized the material in those days. All the penicillin in England was contained in a small box and we had to conserve it carefully. It was quite clear from the experimental and a few clinical results that this material was going to be of the greatest use in the treatment of war wounds, at least those of us who were involved in

the matter were quite convinced of this, but it did not seem likely at that time that there would be enough penicillin to satisfy the really enormous demands from the wounded of the very large armies then in the field, and so in England we turned our attention largely toward the effect of local application. I think one of the things that you will notice in comparing English and American literature on the subject is that we have paid a great deal more attention in England to the possibility of the local use of penicillin. This, as I have indicated, was conditioned by the lack of penicillin, but I think if we consider the matter we shall see that today local application has certain advantages in some cases.

Now these methods were some of them perfectly obvious and some not so obvious. The consideration that we had in mind was that we had a substance which was very soluble and apparently very diffusible, so we could assume that it would diffuse very readily into living tissues; and if it were placed in a wound, it might be supposed that it would penetrate a considerable distance below the surface of the wound. Now that would mean a very distinct difference from any, or practically any, known antiseptic, or antibacterial agent which was known at that time. That was the first thing which led us to suppose that local application might be successful. The other thing which was important was that it was active in the presence of pus, and we might therefore reasonably expect it to work even though there was much pus present. This was a sharp distinction from all the war experience with the sulfonamides as it was fairly clear even at that time that the sulfonamides really did not do much in wounds associated with pus formation. It was also clear that it would be fairly rapidly absorbed and eliminated, and so methods had to be devised for keeping this soluble, diffusible substance in contact with septic wounds. That was the main consideration we had in mind and it necessitated some modification of surgical practice.

Some of you are surgeons and I dare say know something of the modes and ways of surgery in England, and also something of surgical traditions. You can imagine that we had to convince certain of our surgical colleagues to throw over some of their well established principles, and very good principles they were too. We were finally able to try a surgical modification on a very small scale. After a radical mastoidectomy we induced our colleague, Dr. Macbeth, to sew up the wound, having left in a rubber tube down which penicillin was injected every six hours. In this way we were able to get some really good results in the majority of cases and healing by what was, to all intents and purposes, first intention. We used this method when we started to treat war wounds in 1943. The first war wounds were treated in Cairo in 1942 with a very small tube-full of material sent out from Oxford; the wounds treated were all chronic. Then in 1943 a team of people was sent with some penicillin to Algiers and again they treated old wounds. When I say old wounds, I mean they were six weeks or more old. They were nasty, purulent wounds, hardly believable for those of you who only saw wounds in the latter part of the war.

It was quite clear from the observations made on these cases that it wasn't much use treating sepsis late. The results were very second-rate and led us to suppose that war wounds must be treated early.

We induced some very experienced war surgeons, who had been all through the desert campaign, to sew up wounds containing gram-positive organisms which at that time of course was not being done nor even considered. The surgical practice then was to leave them open and let them granulate; the healing of wounds thus took a very long time. But at that stage it was a more or less revolutionary idea to ask the surgeons to sew up such wounds. Most of them were treated by local application of penicillin, and this film which I intend to show you will illustrate some of the techniques which were used and some of the results. Now I know that Colonel Churchill, who was the consulting surgeon in Africa and Italy, didn't like tubes in wounds, and it was a perfectly reasonable attitude to take, but I did get him to admit before he came back to this country that the results obtained in Italy by local application were about the same as those obtained by intramuscular injection by American surgeons. It was a difference in practice and I think it has some interest. Another

point about local application is that we now know that the best way to treat empyemas is by local application, but what is not so commonly known is, as my wife observed, that when you put a dose of say 200,000 units into the empyema cavity, the penicillin remains in the blood for 40 hours or more. She has found, too, that the same phenomenon is encountered after instillation of 100,000 units into wounds.

There is another advantage in local application which I might just call to your attention and that is that if resistant organisms are present, such as some staphylococci, there may be a chance of eliminating them by local application because of the high concentration you can get in contact with the bacteria by this means. By systemic administration you get a relatively small concentration of penicillin in a wound. If you have present a considerable number of organisms, which produce penicillinase, then they may be sufficient to demolish a good deal of the penicillin which comes out of the blood, whereas if you put it in locally, you get the necessary concentration to deal with the gram-positive organisms. There is only one warning I would give you and that is that there is no question that the successful use of local application requires much more care and particularly meticulous surgery. I should just like you to think the matter over for in certain instances local application may be preferable to pushing the plunger of a syringe, and it may give better results.

The film I shall now show you gives the results which were obtained as I have outlined them to you. Like everything in America it moves rather rapidly and I find that the machine here is so modern that it won't project a film taken at the old silent speed. This film I took myself with an ordinary Ciné-Kodak under some difficulty because we had to move all the patients into corridors since the theaters were blacked out and we had no lights for photography. So there are technical imperfections in the film and some of the sequences are incomplete. I can assure you that the surgeons of the Eighth Army didn't work as rapidly as they may appear to here. The film was taken at 16 frames per second and I think it is going to be projected at 24 frames, so if you will excuse the technical deficiencies, you may get some idea of the early techniques—now a matter of history.



## SOME PROBLEMS OF PROTEIN DEFICIENCY

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PROTEIN deficiency as seen in patients is nearly always a complicated phenomenon, for not only does a deficiency usually exist in relation to other primary foodstuffs, but there is also often a deficiency in one or more of the known vitamins, as well as alterations in the fluid and electrolyte balance and stores of the body. The subject can hardly be discussed without presenting certain generalizations.

To maintain good nutrition an adequate amount and an adequate variety of various primary and accessory foodstuffs, minerals and water must be ingested, and these must be absorbed and utilized in the body economy.

A deficiency in the protein nutrition per se results in many changes in physiological activity and certain of these changes can be demonstrated before serious protein starvation is evident.

Prolonged subsistence on minimal levels of protein intake, as of other foodstuffs, is hazardous. Normal growth and normal utilization of protein depend upon the presence of eight to ten essential amino acids.<sup>1</sup>

Proteins are an important part of all cells, including the nuclei. The enzymes, hormones and antibodies are in the main protein in character.

The proteins, especially the plasma proteins, play an important role in maintaining normal relations between intracellular and extracellular body fluid.

The plasma proteins are complex, but consist of two main groups, the albumins and the globulins. Each of the subfractions has specific physiological functions. Albumin is responsible for approximately 85 per cent of the colloid osmotic effect of the plasma proteins. Fibrinogen, prothrombin and the antibodies are found in the globulin fractions.

Changes in the protein nutrition, as a rule, affect the albumin fraction first although the first effect of protein undernutrition is the reduction in the amount of protein stored in the tissues of the body. Thus hypoproteinemia is indicative of a serious reduction in the "labile" or reserve stores of body protein.

There is evidence that gross evident edema does not occur when the serum albumin is greater than 3.0 grams per cent and is usually present when it is less than 2.5 grams per cent. The administration of large amounts of neutral sodium salts will increase the edema occurring at any given level of the plasma protein.

It must be remembered that as soon as the concentration of the serum albumin falls below the accepted normal a graded retention of fluid takes place and that palpable edema indicates that the serum albumin concentration has reached a critical level. The amount of fluid which may be stored in tissues during latent edema may be large even though pitting edema is not demonstrable.

When anemia and hypoproteinemia coexist it is important to provide adequate protein and iron for hemoglobin synthesis and an additional amount of protein for storage and plasma protein regeneration. Hemoglobin synthesis will take place at the expense of protein storage and plasma protein unless large amounts of protein are ingested.

The determination of nitrogen balance is important in protein nutrition for by this means only can it be known whether protein is being stored in the body or lost from it. An individual is in positive nitrogen balance if the intake of nitrogen by mouth or parenterally exceeds the amount lost from the body by all means, and in negative nitrogen balance if output exceeds the intake. In considering output it is important to take into account not only the output in the urine, but also that lost from wounds and through suppuration. A negative balance occurs

when there is excessive breakdown of body protein, abnormal loss from any source or when protein intake is inadequate. A positive balance occurs when the intake of foodstuffs is adequate both in the amount of protein and in total calories.

Although a positive nitrogen balance can be obtained on a relatively low protein intake if the caloric intake, especially of carbohydrate, is adequate, such a dietary is not safe over long periods, for it does not provide for sudden demands during illness or injury.

Forced feeding considerably in excess of the daily requirements leads to the building up of the food stores. A large portion of the excess protein in such dietaries is stored as reserve protein and can be called upon during periods of stress and strain without requiring the catabolism of important fixed cellular protein.

According to Peters and Van Slyke<sup>2</sup> serum albumin is regenerated at the rate of 25 grams or more per day depending upon the adequacy of the dietary intake provided protein is not being lost in excessive amounts from the body.

The restoration to normal of a reduced serum protein content must not be taken as an indication that the tissue deficit of protein has been restored, for depleted reserve stores of protein are not, as a rule, significantly replenished until the concentration and total amount of serum protein have returned to normal.

Proteins are not alike in their nutritive value, for they vary greatly in their content of the nutritionally essential amino acids. The proteins of animals are, as a rule, complete proteins, although even in this group considerable variations are found in the content of the essential amino acids. The vegetable proteins are not so likely to be complete proteins.

Some proteins, such as gelatin which is of animal origin, are incomplete proteins and when used in the dietary should be supplemented by proteins which contain the missing essential amino acids. Supplementation is, as a rule, considered excellent nutritional practice, but supplementation must take into account the necessity of providing in the protein ingested or injected all of the essential amino acids.

#### CAUSES OF PROTEIN DEFICIENCY

In general there are five major causes of protein deficiency.

##### 1. Insufficient Intake of Protein—Chronic Mal-

nutrition—This condition, in the traditional sense, results when there is an inadequate intake of protein to meet the nutritive and metabolic demands of the body. There may be an absolute quantitative deficiency in protein intake, or the protein while quantitatively sufficient, may be qualitatively inadequate in that as ingested it fails to provide the amino acids essential for a good nutritive state. Very frequently the deficiency results from an intake quantitatively and qualitatively inadequate.

I had during the war years an opportunity to observe this in civilians and also in military personnel in the Far East. Famine in India is a many sided nutritional problem but a lack of adequate protein is the major cause of famine edema which is so frequently seen in those people whose animal protein intake is often negligible.

Large numbers of the soldiers flown from China to India to provide replacements for the Chinese armies fighting in Burma were hypoproteinemic, concentrations of serum protein of 5.5 grams per cent being the rule rather than the exception. One hesitates to think what would have happened to them following serious illness or injury had they not been provided with an adequate dietary from British and American sources for some weeks or even months prior to placing them in combat.

Nutritional edema, the result of a diet low in total calories and in protein, is common among the poorer natives of the Far East where large portions of the population often have to live on a dietary inadequate in composition and far below that necessary for the simplest subsistence level. The average G.I. was accustomed to compare their work performance with that of some of our former W.P.A. workers, but those of us who knew something of the native coolie's food consumption marveled at what they did. We could not do as much without years of conditioning to such an inadequate diet.

Youmans and his associates<sup>3</sup> have studied this condition in certain areas of our own country. The external evidences of prolonged protein undernutrition may not be readily evident until the individual is subjected to the increased demands associated with illness or injury.

At times an inadequate intake is imposed upon the patient by a physician ignorant of nutritional requirements. At others the patient restricts intake because of pain, anorexia, nausea or vomiting. The fallacious concept, still propagated by many physi-



cians, that a high protein intake is harmful in pregnancy all too frequently results in maternal protein deficiency and in a decrease below the normal in the expected weight and length of the infant at birth. The prolonged maternal deficiency may result in anemia, poor uterine tone, a lowered resistance to infection and impaired lactation. Finally, Tompkins,<sup>5</sup> in a study of nutritional deficiencies in pregnancy, showed that in the women on a deficient diet toxemia with mild hypertension was four times more frequent than in those on a well balanced high protein diet; edema was five times as frequent, and pre-eclampsia eight times as frequent.

The restricted food intake of the chronic alcoholic is another example of this type of deficiency, the result of which is chronic malnutrition, a serious loss in the reserve stores of protein, anemia and hypoproteinemia, together with the events that follow these biologic abnormalities. It is more than possible that herein lies the danger of alcoholism.

Much of the groundwork of our present knowledge of the fundamental aspects of this subject was laid by John Peters and his associates<sup>6</sup> at New Haven. Their observations led to a clearer understanding of the distribution of fluid and electrolytes in the body, the relation of malnutrition to serum protein deficiencies, and the relationship of these to edema. The factors conditioning edema are multiple depending in part upon the colloid osmotic pressure of the serum protein, in part upon the degree of hydration, and in part upon the amount of neutral sodium salts made available to the organism.

2. Impaired Digestion or Absorption of Protein—These conditions are found in certain chronic diseases of the gastro-intestinal tract associated with abnormalities in the secretory activity of the stomach, small intestine, pancreas or liver. Inadequate absorption may occur in patients with intestinal ulceration or new growths, in inflammatory lesions or edema of the alimentary tract, or in conjunction with diarrhea. It is at times seen in the presence of fistulae of the small bowel and is constantly observed in gastrojejunal fistulae.

The nutritional deficiencies observed in this group are nearly always complex ones and are within a brief period associated with anorexia and a further restriction in the intake of food. Such a vicious circle results in an intensification of the dietary deficiencies and a further drain upon the tissues of the body.

3. Impaired Protein Synthesis—The liver is inseparably associated with protein synthesis. It is generally agreed that albumin and fibrinogen are formed in the liver. Certain globulin fractions are without doubt normally synthesized in part in the liver. Addis and his associates,<sup>7,8</sup> demonstrated that the liver contains under normal conditions a readily mobilizable reserve store of protein which is depleted during fasting and restored following adequate feeding. Addis has called this readily depleted protein "labile protein." While it cannot be demonstrated that this "labile" or "reserve" protein is chemically different from the general cytoplasmic protein, it can easily be demonstrated that during a seven day period of fasting the liver rapidly loses as much as 40 per cent of its total protein and as rapidly regains it following a period of completely adequate feeding.

In the presence of severe hepatic disease, acute or chronic, protein synthesis is disturbed. Myers and Keefer<sup>9</sup> found that albumin synthesis was more severely disturbed in hepatic cirrhosis than was globulin synthesis. The disturbance may be sufficiently great to result in the inversion of the normal albumin-globulin ration. There results not only hypoproteinemia but a serious reduction in the stores of reserve protein in the body.

The protein deficiency which results from serious hepatic disease is not due to an insufficient protein intake although it may be a factor in the milder cirrheses. It is due to a fundamental disturbance of function which prevents the liver from utilizing in a normal manner the amino acids as building stones for protein synthesis, be this the serum albumin, the reserve stores of protein or the protein immediately necessary for tissue growth and regeneration.

In many hepatic disorders, the cirrhosis, toxic and infectious hepatitis, and primary and secondary malignancy, the disturbance in protein synthesis usually parallels the degree of hepatocellular injury and destruction. In the absence of proteinuria and other discernible causes of protein loss, and with an adequate intake of protein, hypoproteinemia and its sequellae, or associated phenomena, should be considered as evidence of inadequate protein synthesis.

4. Increased Loss of Protein From the Body—Some protein, in the form of the nitrogenous products of protein catabolism, is constantly excreted in the urine. This is a normal mechanism and provides for the disposal of such nitrogenous material as is no

longer useful in the body economy.

The amount of protein lost in the urine in certain lesions of the kidney may, however, be so great that under none of the conditions now available can the protein deficiency be corrected until a more normal renal function is established. Here again the fraction of the serum protein which suffers to the greatest degree is the albumin and it was because of this that the earlier investigators called the condition albuminuria. The later knowledge that the urine in nephritis and nephrosis may contain other proteins led to the use of the more exact term—proteinuria. With the continued loss of protein in the urine there occurs a reduction in the concentration of the serum protein, the reduction in concentration and in total amount being due largely to a reduction in the albumin fraction.

In the dysenteries and in colitis, especially ulcerative colitis, the loss of plasma and blood may be considerable and in addition there is frequently an impaired absorption of protein. In long-standing suppuration, in conditions associated with internal exudates or transudates, as in peritonitis and thoracic empyema, and in extensive superficial injury, such as large superficial burns, the loss of plasma protein may be very great.

In addition, in most of these conditions there is apt to occur an increasing anemia unless special efforts are made to prevent it. The significance of an anemia, especially a marked reduction of the hemoglobin in the presence of a protein deficiency must be clearly understood. Heath and Taylor<sup>10</sup> showed that in hypochromic anemia hemoglobin was formed in response to iron therapy even though the protein intake was so low as to cause tissue or plasma protein deprivation. In such circumstances the nitrogen required for the synthesis of hemoglobin must come, in part at least, from proteins of the plasma and tissues. By increasing the carbohydrate and fat in order to meet food energy requirements and by providing adequate protein as well as iron, hemoglobin regeneration will proceed normally and a loss of tissue and plasma nitrogen will be prevented. If the diet is adequate in all respects not only will hemoglobin synthesis take place promptly, but once the acute crisis is over tissue storage and regeneration can again proceed in a more normal manner.

Whipple<sup>11</sup> has summarized this relationship as follows: "We believed that in a dog, both anemic

and plasma depleted, we could influence the protein flow toward hemoglobin by one food factor or toward plasma protein by another food. . . . To our surprise we observed that such dogs (hemoglobin and plasma protein deficient) always produce more hemoglobin than plasma protein no matter what diet protein is used. . . . Hemoglobin in its production may draw on the plasma protein but hemoglobin stands apart in the protein economy and does not contribute freely to the protein pool. On the other hand, the body guards jealously the fabrication of hemoglobin and given a real need for both plasma protein and hemoglobin the protein flow favors hemoglobin, which under these circumstances is produced in more abundance than the plasma protein." Every possible effort should be made to correct an existing anemia in protein deficient patients in whom attempts are being made to correct the protein deficiency.

5. Increased Catabolism of Protein in the Body—Some protein is constantly being broken down in the normal processes of metabolism. In fever, in hyperthyroidism, as well as in other conditions associated with an increase in the metabolic rate, such as myelogenous leukemia, there occurs a marked increase in the rate of protein breakdown. In the severe infections, even those unassociated with suppuration, a rapidly developing hypoproteinemia is often observed.

The effect of such a disturbance on the hemodynamics of the circulation may be considerable. We have shown,<sup>12</sup> as have others, that the hypoproteinemic dog is more susceptible to hemorrhagic shock, and no one would question the increased susceptibility of the undernourished individual to traumatic shock.

Cannon and his associates<sup>13</sup> have pointed out the close relationship existing between protein deficiency and an inability to develop adequate antibodies. This very important field is just now being rapidly extended, but the knowledge already gained begins to complete the mosaic, which was previously fragmentary, regarding the relationship between the nutritional state and the general resistance of the patient.

Rose and I<sup>14</sup> have repeatedly observed that the failure of a patient suffering from hyperthyroidism to gain weight during the period of preoperative therapy is of serious consequence in that the morbidity and mortality of operation is greatly increased



in such patients.

The body requirements of protein cannot fail to be met, even for relatively short periods, in those subjected to serious acute illness or injury without profound physiological changes, and when this occurs over relatively protracted periods, not only is morbidity increased and convalescence retarded, but the mortality of a variety of conditions will be increased. Tillett and his associates<sup>15</sup> have shown that the rapid loss of serum and tissue protein may be an important factor in the cause of death of patients following severe bacterial infection in whom the infection has been controlled by chemotherapy. This entire field, which is only now receiving the attention of competent investigators, will without doubt provide information of great value in the care of patients. When it is considered that following even relatively minor operations there takes place a marked increase in protein catabolism and following major procedures a more extensive protein breakdown, the significance of an adequate nutritive state becomes even more apparent.

#### SOME SPECIFIC ASPECTS OF PROTEIN DEFICIENCY

The selection of a few illustrations of the specific effects of protein deficiency must, of course, be conditioned by one's interests, both clinical and experimental. As a surgeon my attention has been directed to a few of the conditions resulting from periods of protein deficiency. I shall describe certain of these although I might well have selected many others, medical or surgical, of equal or even greater significance.

Lund and Levenson<sup>16</sup> have, in fact, called attention to the importance of correcting protein deficiencies in shock, in local or general hypoproteinemic edema, in the healing of wounds, in immunity to infection, and in the detoxification of certain noxious substances. To these should be added the importance of correcting a protein deficiency during convalescence, for it is at such a period that a great deal can be accomplished in facilitating a speedy and complete recovery.

Every operation, as every trauma or infection, is associated with a period of increased protein catabolism resulting in most instances in a negative nitrogen balance. Cuthbertson<sup>17</sup> has shown that a negative nitrogen balance occurs for a period of time after a simple fracture, and Rhoads and Kasinskas<sup>18</sup> have shown that a serious protein deficiency

retards the healing of fractures. Thus disease or injury, or operation may be associated with the most serious consequences because of the increased demands which they may make on protein reserves.

It is now generally accepted that in this sense hypoproteinemia predisposes to poor wound healing, wound dehiscence, visceral as well as subcutaneous edema, failure of fractures to unite even when in excellent anatomical position, and to a reduced resistance to local and generalized infections.

#### WOUND HEALING

In 1934, Harvey,<sup>19</sup> in the discussion of a paper on wound disruption by Meleney and Howes,<sup>20</sup> stated: "There are constitutional alterations which may lead to weakening of the wound. In a young infant, badly nourished, with pyloric stenosis, for instance, the wound is not likely to heal well. With carcinoma of the stomach the wound is not likely to heal well. Senility per se has nothing to do with it, but with extreme malnutrition and anemia the wound will not heal well." In 1935, Smelo,<sup>21</sup> working in our laboratories on certain aspects of superficial wound healing, concluded that "factors other than the local dressing appear to play the dominant role determining the rate of wound healing."

We<sup>22</sup> have shown that dogs which have been made protein deficient by plasmaphereses and prolonged feeding of a low protein diet but amply supplied with the known vitamins have a marked delay in fibroblastic proliferation. The hypoproteinemia in our dogs was but one easily measurable indication of protein starvation. We were at first inclined to attribute the delay in fibroblastic proliferation to the presence of edema, and it very likely plays a part, but we believe that the mechanism is in large part associated with a profound disturbance in protein metabolism.

Admont Clark<sup>23</sup> showed that on a diet high in protein there was no quiescent period in the repair of wounds and Harvey and Howes<sup>24</sup> have reported that such a diet causes accelerated fibroblastic proliferation. Without adequate building stones repair cannot take place.

Hartzell, Winfield and Irwin<sup>25</sup> have found hypoproteinemia to be more frequent in patients with wound disruption than is a vitamin C deficiency, and Mulholland and his co-workers<sup>26</sup> and many others have now demonstrated the amazing healing which can take place in certain decubitus ulcers

when nothing else is changed in the care of these patients except the addition of an adequate amount of protein to the diet.

#### HYPOPROTEINEMIA AND EDEMA

Jones and Eaton<sup>27</sup> first reported that edema resulting from hypoproteinemia was not uncommon in patients before and after operation for gastrointestinal lesions, especially those of the stomach and duodenum. The large amounts of sodium chloride given such patients to overcome their dehydration serve to intensify the edema occurring at any given concentration of the plasma protein.

Hypoproteinemia may give rise to so intense an edema following a gastro-intestinal anastomosis as to mimic in every way a mechanical defect of the technic or anastomosis.<sup>28,29</sup> The impediment to normal gastro-intestinal flow is frequently the result of an accentuation and prolongation of the edema associated with hypoproteinemia and the trauma of operation.

On a number of occasions we have seen such stomata fail to function normally until by one means or another the hypoproteinemia was overcome. When this was accomplished, normal emptying took place and the fear that the complication was due to a defect in the method of anastomosis gave way to the feeling that we should pay more attention to nutrition and the factors which are responsible for keeping fluids in blood vessels.

#### FRACTURES

Cuthbertson<sup>17</sup> found evidences of a markedly negative nitrogen balance following fractures. The nitrogen lost in the urine was as great as 25 grams for twenty-four hours, and a negative nitrogen balance continued for many days unless strenuous attempts to increase the intake of protein were made.

Rhoads and Kasinskas<sup>18</sup> have shown that a deficiency of protein markedly effects bone healing. Dogs rendered protein deficient show a marked delay in bone healing. They found that sometimes for as long as 76 days after a division of a bone in hypoproteinemic animals, there was little evidence of callus formation while the animals with normal protein stores showed good callus formation at the end of 39 days. The cause of the delayed bone healing is not at once clear. Hypoproteinemia is known to interfere with the fibroblastic repair which normally precedes callus formation. Concurrently, hypoproteinemia also causes a hypocalcemia since

approximately half of the serum calcium is bound to the serum protein. Further research is necessary to solve this problem.

#### LIVER DAMAGE AND LIVER REGENERATION

Thirty-four years ago Opie and Alford<sup>30,31,32</sup> reported that the incidence of necrosis of the liver following the use of chloroform could be greatly reduced if a diet high in carbohydrate was administered to dogs for several days prior to anesthetization, and that increased susceptibility occurred if the diet was high in fat. Surgeons, internists and even physiologists apparently accepted the data which these investigators presented. This in spite of the fact that Moise and Smith,<sup>33</sup> in 1934, called attention to the inadequacies of the diets used by these early investigators which diets were neither pure nor adequate to meet the energy requirements of growing dogs.

Data which Goldschmidt, Vars and I<sup>34</sup> have obtained demonstrate that a liver high in lipid content and low in available protein is maximally susceptible to injury following chloroform anesthesia while a liver low in lipid content and high in available protein is maximally protected against injury. Even in the presence of a high concentration of liver lipid we found that a diet adequate in its protein and caloric content and administered for several days prior to anesthetization greatly reduced the incidence of necrosis of the liver.

Whipple and his co-workers<sup>35,36</sup> have since confirmed our data showing that a diet adequate in protein will protect the liver from injury during chloroform anesthesia and have extended these observations by demonstrating that a similar diet protects the liver from arsphenamine necrosis, while Smith<sup>37</sup> has found that it protects the liver from selenium poisoning.

More recently Miller, Ross and Whipple<sup>38</sup> have stated that methionine and to a lesser extent cystine are the active fractions of the protein molecule which offer this protection against chloroform.

If regeneration and repair are to be facilitated following injury, there must be provided a sufficient amount of an adequate protein in the diet following operation. Maximal regeneration and repair can not take place unless the diet consists of foodstuffs which are essential for cellular repairs. The problem here is analogous to the faulty wound healing which may occur during the hypoproteinemic state.



#### NITROGEN IMBALANCE AFTER OPERATION

Not only does a protein deficiency exist in many instances prior to operation, but the increase in protein catabolism which is brought on by many operations may induce this or intensify it subsequent to operation. This is all the more true when extensive tissue trauma leads to exudation or when infection supervenes. Elman<sup>39</sup> found that the negative balance after certain operations was such as to result in a rapidly increasing protein deficiency and the studies of Browne, Schenker and Stevenson<sup>40</sup> confirm those of Elman.

Although the protein stores may appear superficially to be adequate prior to operation, hemorrhage, serum loss, infection and suppuration, and the increased protein catabolism following operation may result in such a drain on the available stores of protein as to initiate a series of complications which in spite of a technically perfect operation cause a fatal ending. This is all the more true when acute starvation is induced for periods after operation. The loss of weight in the hospital must be taken as an indication of the extent to which we have failed to meet the energy requirements of the patient.

#### THE CORRECTION OF PROTEIN DEFICIENCY

We have used various methods in attempting to sustain or reinforce the protein stores of the body either before or after operation. The exact method used in any given instance depends upon a number of factors. On one thing all investigators are agreed, the best route to supply the energy requirements of a patient and to add to the various stores of body foodstuffs is the oral route. When there exists no contraindication to oral or oro-jejunal feeding, other routes should not be used except for supplementary feeding.

The diet should be one which the patient will eat. It is not what is offered to the patient that counts, it is what he actually eats. Since nearly all deficiencies are mixed ones, the dietary when offered by mouth should be ample for good nutrition.

The ordinary patient does well on a protein intake of 1.0 gram per kilogram of body weight per day. During short periods even this amount may be reduced if sufficient carbohydrate is added to the diet. In pregnancy and lactation the protein intake should be increased by 50 to 100 per cent. In extensive superficial burns and extensive trauma of other types, and in severe infections, especially those

associated with suppuration, the protein intake should be greatly increased. A positive nitrogen balance may not be obtainable in the presence of acute injury or infection under any program of feeding. Not only are large amounts of protein often necessary, amounts as high as 300 grams per day, but the total caloric intake should likewise be increased from 2,000 to 2,500 to 3,500 to 4,000 calories a day. We have found<sup>41</sup> that after major abdominal operations, such as a gastric resection, mixed jejunal feedings in which the twenty-four hour intake of nitrogen is 0.3 gram and the caloric intake not less than 30 calories per kilogram of body weight will usually result in a positive nitrogen balance. These amounts in our experience must be increased when parenteral feeding alone is resorted to.

When oral feeding is used, whole foodstuffs should be given. There is no beneficence in feeding protein hydrolysates unless there is evidence of faulty digestion. Feeding of mixtures of polypeptides and amino acids may result in an absorption rate of amino acids which is more rapid than can be resynthesized by the liver, especially when the function of this organ is not normal.

During the normal digestion of protein and the absorption of amino acids the liver uses these for replacing and building tissue and plasma protein, and the remainder is deaminated with the formation of carbohydrate and the production of nonprotein nitrogenous products which are excreted in the urine. Some of the protein-split products are utilized in antibody formation, some to form fibrinogen and some to assist in the formation of hemoglobin.

Koop and his associates<sup>42</sup> have provided good evidence that force feeding prior to operation is of real value if this can be done, for while the amount of nitrogen lost in the urine subsequent to operation may still be considerable, the amount of nitrogen stored as protein by the force feeding leaves the patient with a credit in his storehouses.

One of the most important and fascinating developments in postoperative care has been the wider application of early ambulation. As this has been extended, surgeons have given more specific attention to convalescence and reconditioning beginning with the period immediately after operation. Internists also are more cognizant of the importance of speeding up the convalescence of those recovering from disease. In order that this be achieved it is important to increase the consumption of adequate

foodstuffs. It is only in this way that the losses encountered during periods of underfeeding, illness, and injury can be promptly corrected.

After the immediate crisis of the operation has passed, the patient is placed on a diet containing 125 to 150 grams of protein, and carbohydrate and fat sufficient to provide from 2,600 to 3,500 calories per day.

There are other means of supplying foodstuffs when voluntary ingestion is impossible or when only small amounts can be administered by this route. It is possible to use protein hydrolysates by tube feeding into the stomach or jejunum in conjunction with glucose and even fat. In our experience diarrhea very often results when large amounts are fed in this manner. Protein can be administered as human plasma, human albumin, as hydrolysates of casein or fibrin, as gelatin or as whole blood.

There are practical contraindications to the use of large amounts of plasma or albumin intravenously in that the greatly increased blood volume which occurs under such circumstances may so increase the circulating volume as to lead to cardiac embarrassment. These substances are very useful during temporary periods of hepatic insufficiency, but they are expensive and evidence is available that they do not serve adequately for long periods as the only source of protein in the presence of serious protein deficits.

Casein, lactalbumin and fibrin hydrolysates, reinforced with glucose, have been widely used intravenously to increase the total caloric intake. It has been found that administered in sufficient amounts—0.5 gram of nitrogen and 30 calories per kilogram of body weight per day—a positive nitrogen balance can usually be maintained.

Gelatin in our hands has proven to be an excellent plasma substitute when an acute plasma deficiency exists. Gelatin is, however, not a complete protein in that it is lacking in certain of the essential amino acids, so that it is an unsatisfactory source of nutritional protein. Recently Brunschwig<sup>43</sup> has published data which suggest that, reinforced with the necessary essential amino acids which are lacking in gelatin, a positive nitrogen balance can be maintained and Riegel<sup>44</sup> and others have shown that when a protein hydrolysate and gelatin are used in equal amounts in terms of nitrogen, a positive balance is attainable.

Whole blood is useful in overcoming an anemia

in protein deficient patients, but it is not an economical source of protein in protein deficiency.

A considerable amount of literature has been built up on the value of the sulfur-containing amino acids especially methionine in protecting the liver from certain noxious agents, in reducing the nitrogen lost in the urine after severe injury<sup>45</sup> and in the repair of injured viscera.<sup>46</sup> There can be no doubt but that methionine is at times useful in all of these conditions, but all investigators are not in agreement regarding its usefulness.<sup>47</sup> In attempting to reconcile the negative results of some investigators with the positive ones reported by others I have been impressed by the fact that unsuccessful results have been obtained in animal and clinical investigations where the dietary being fed had for some time been ample in its protein content. Thus the patient or animal had been receiving adequate amounts of methionine. On the other hand, when for a period a protein deficiency had existed the administration of methionine has been proven to be exceedingly useful. Thus methionine supplementation in man subsisting on a dietary containing only 40.0 grams of protein and adequate carbohydrate and fat will not result in a reduction in the nitrogen lost in the urine, but it will do so on a similar isocaloric dietary where the protein is reduced to 20.0 grams daily. It is important to stress the point that methionine has been proven of value only when the dietary is inadequate and the protein stores have been depleted. Its usefulness, therefore, depends upon whether or not the patient is already receiving an optimal amount of methionine in the daily ration.

#### CONCLUSIONS

The more intelligent efforts now being directed to improve the general nutrition of patients suffering from medical and surgical lesions are resulting in a lowering of the morbidity of these conditions, in a reduction in their mortality, and thus greater safety of radical operative procedures, and in shortening of the period of convalescence. Good nutrition requires adequate amounts of the primary and secondary foodstuffs—minerals and water. Of these the protection of the protein reserves of the body or their restoration should they have become depleted is of primary importance.

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## ANOMALIES OF THE UROGENITAL TRACT IN SOLDIERS

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THIS IS A SURVEY of 104 cases of congenital anomalies of the urogenital tract treated on the urological service of AAF Regional Hospital, Hunter Field, Georgia, over a period of 32 months. During this time the total hospital admissions were 16,734 patients; 1,187 of this total were admitted on the urological service. Congenital anomalies of the urogenital tract accounted for 8.9 per cent of the total urological admissions. The anomalies will be enumerated as follows: (1) congenital hydronephrosis, (2) ureteral duplication, (3) anomalies of the kidney as to numbers, size, form and position, (4) anomalies of the bladder, and (5) anomalies of the genitalia.

## I. CONGENITAL HYDRONEPHROSIS

There were 30 cases seen. The degree of hydronephrosis varied from mild to moderate and severe. The etiological agent causing the hydronephrosis was obstruction at the uretero-pelvic junction. Of the 30 cases, seventeen (17) were treated surgically. In 7 of these 17 cases, conservative surgical procedures were carried out. In the remaining 12 cases, nephrectomy was necessary. The interesting finding in this group was the large number of cases with a severe hydronephrosis that had persisted undiagnosed for a long time due to the presence of vague symptomatology.

*Case 1.* This patient G. P., age 27, gave a history of recurrent attacks of pain in the upper portion of the abdomen for many years. He had had three previous admissions at other hospitals. A day before the present admission, he completed a long train ride and had a moderate amount of discomfort in the upper portion of the abdomen. Tenderness was present in the right flank posteriorly. Bladder urine showed the presence of 1-3 pus cells per high power field. An intravenous urogram showed a hypertrophied left kidney with no evidence of excretion of diodrast by the right kidney. At cystoscopic examination, no urine appeared from the right ureteral orifice. The p.s.p. renal function test for the left kidney was 25 per cent in 15 minutes, with no evidence of excretion of dye by the right kidney.

A right uretero-pyelogram revealed a huge right hydronephrosis due to obstruction at the uretero-pelvic junction (Figure 1). At operation a large hydronephrotic kidney was removed. The patient made an uneventful recovery and was returned to limited duty.



FIGURE 1

Right uretero-pyelogram showing a severe hydronephrosis due to obstruction at the uretero-pelvic junction

*Case 2.* This patient C. R. B., age 27, had an operation on his left kidney ten years previously. He was in good health up until January 1945 when he fell, injuring his left side. He developed pain in the side and noticed bloody urine. He was confined to bed for five days and then returned to full duty. In August 1945 he again noticed bloody urine and was transferred from his home station to this hospital. Tenderness was present in the left flank posteriorly. Bladder urine showed the presence of 10-12 pus cells per high power field. There was no evidence of bacterial growth. Intravenous urogram showed a normal right kidney with no evidence of excretion of diodrast by the left kidney at the end of one hour.



Cystoscopic examination showed failure of urine to appear from the left ureteral orifice. The p.s.p. renal function test for the right kidney was 22 per cent in 15 minutes; there was no dye excreted by the left kidney. A left uretero-pyelogram showed a severe left hydronephrosis with obstruction at the uretero-pelvic junction (Figures 2 and 3). At operation a large hydronephrotic kidney was removed; there were numerous aberrant veins which encircled the upper end of the ureter (Figure 4). This patient made an uneventful recovery and at the time of his dismissal from the hospital he was eligible for discharge from the service.

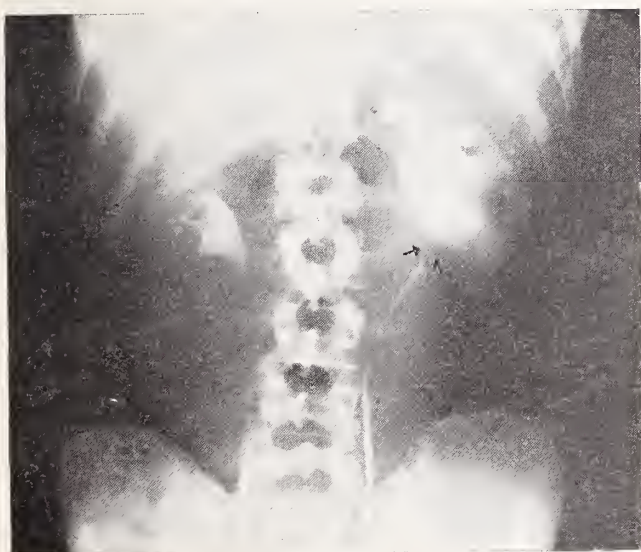


FIGURE 2

Left uretero-pyelogram showing obstruction at the uretero-pelvic junction due to an aberrant renal vessel



FIGURE 3

Left uretero-pyelogram showing dye retained in the renal pelvis, with the patient in upright position

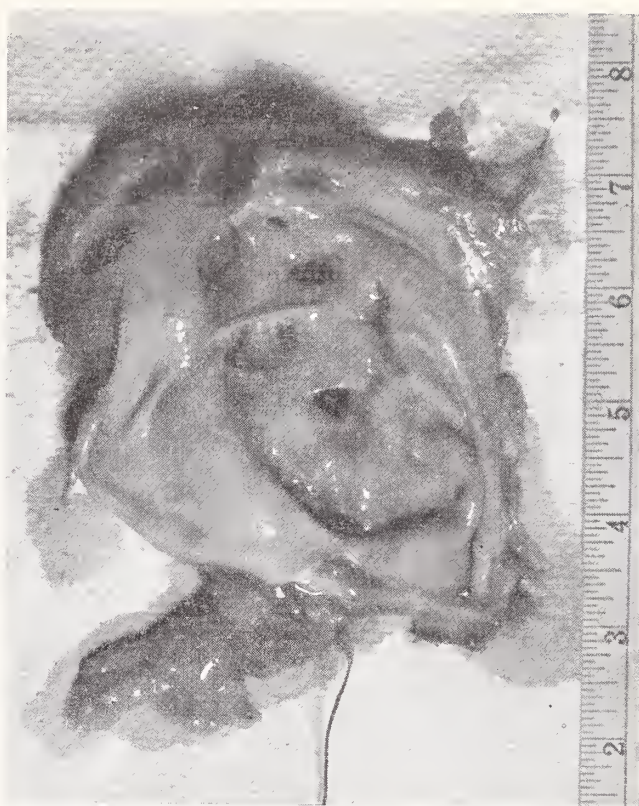


FIGURE 4

Kidney specimen showing marked atrophy due to hydronephrosis

*Case 3.* This patient C. C. J., age 19, had two previous hospital admissions. He had been referred to me because of his complaints of urinary frequency. His chief complaint was discomfort in his right side. Abdominal examination revealed fullness in his right side with associated tenderness. A large mass was palpable in the right side of the abdomen. The lower pole of the kidney extended to the iliac crest. Bladder urine showed the presence of many pus cells per high power field. Urine culture showed the growth of bacteria, non-hemolytic staphylococcus albus. Intravenous urogram revealed a hypertrophied left kidney without any evidence of excretion of diodrast by the right kidney at the end of four hours. Cystoscopic examination showed failure of urine to appear from the right ureteral orifice. The p.s.p. renal function test for the left kidney was 28 per cent in 15 minutes; no dye was excreted by the right kidney in 15 minutes. A right ureteropyelogram showed a complete obstruction at the upper end of the ureter (Figure 5). The kidney removed at operation was a huge hydronephrotic kidney of tissue-like consistency, filled with 5,000 cc. of urine (Figure 6). The renal pelvis was ventral in position; aberrant vessels crossed the upper end of the ureter anteriorly as they entered the lower pole of the kidney. The



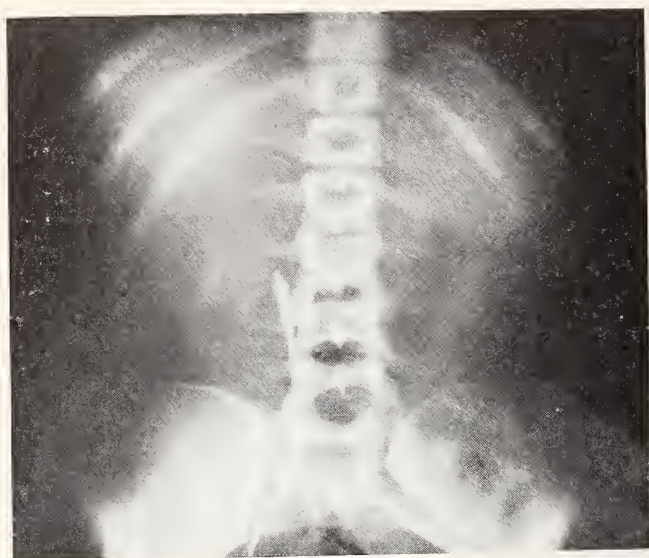


FIGURE 5

Right ureterogram showing a complete block at the upper end of the ureter

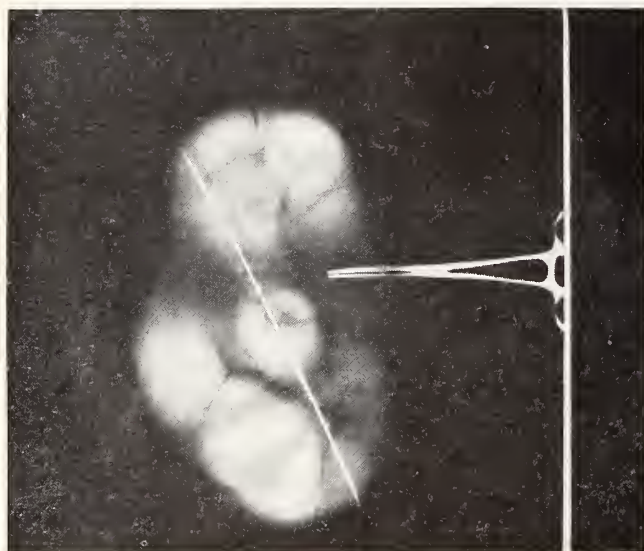


FIGURE 6

Kidney specimen filled with diodrast showing a huge hydronephrotic sac

lumen of the upper end of the ureter was very small in calibre (Figure 7).

## II. ANOMALIES OF URETERAL DUPLICATION

A total of 26 cases were seen. Patients in this condition are prone to develop disease; the commonest complications are infections and hydronephrosis. The most common symptoms in this group is pain and associated urinary disturbance due to infection.

Unilateral bifid pelvis	6 cases
Bilateral bifid pelvis	6 cases
Unilateral double pelvis and single ureter	7 cases
Bilateral double pelvis and single ureter	2 cases
Unilateral double pelvis and double ureters	5 cases

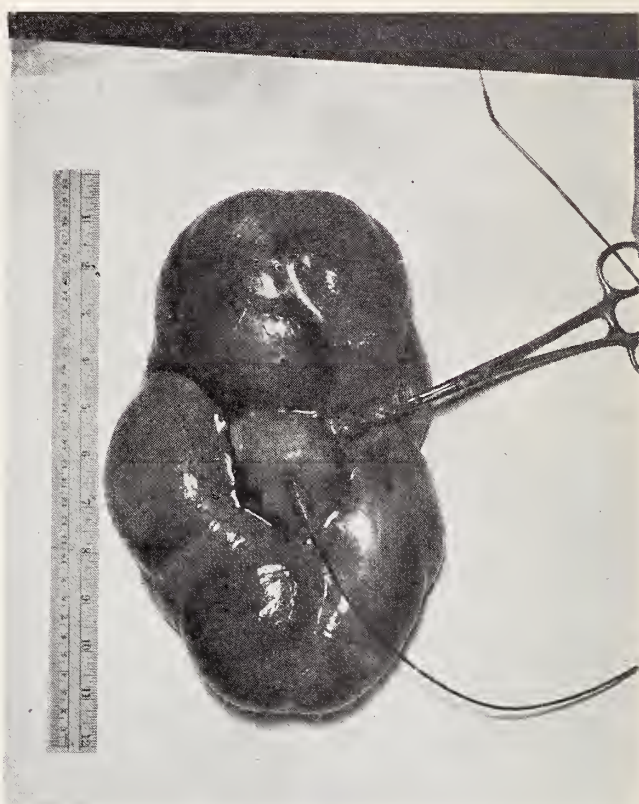


FIGURE 7

Kidney specimen with the renal pelvis ventral in position. The upper end of the ureter was narrow. An aberrant renal vessel crossed the uretero-pelvic junction

In this series 25 cases were treated medically; one necessitated a nephrectomy.

*Case 1.* Patient with a double pelvis, single ureter and associated pyelonephritis due to staphylococcus and colon bacillus. Treated with urinary antiseptics (Figure 8).

*Case 2.* Patient with a double pelvis and double ureter and associated pyelonephritis due to e. colon. Treated with urinary antiseptics (Figure 9).

*Case 3.* Patient with a double pelvis, single ureter and associated pyonephrosis of the lower pole; nephrectomy was performed.

## III. ANOMALIES OF THE KIDNEY AS TO NUMBERS

This group accounted for three patients. These were all cases of unilateral absence of a kidney. The diagnosis was made by (1) lack of any kidney shadow on involved side, (2) hypertrophy of the opposite kidney, (3) absence of ureteric ridge and orifice in the bladder, (4) p.s.p. renal function test for the hypertrophied kidney was double in fifteen minutes.





FIGURE 8

Left uretero-pyelogram showing a double pelvis and single ureter entering the bladder



FIGURE 9

Left uretero-pyelogram showing a double pelvis and separate ureters entering the bladder

*Case 1.* This patient E. V. S., age 27, was admitted in the hospital on the medical service because of bronchitis. Urinalysis revealed albumin in the urine. Eight years previously the same finding had been made. At present examination intravenous urogram showed no evidence of a right kidney shadow, and no excretion of dye. The left kidney was large with an abnormality of rotation. The ureter on the left side had an abnormal insertion into the pelvis (Figure 10). Cystoscopic examination revealed an absence of the right ureteric ridge and orifice. The p.s.p. test for the left kidney was 25 per cent in 15 minutes.

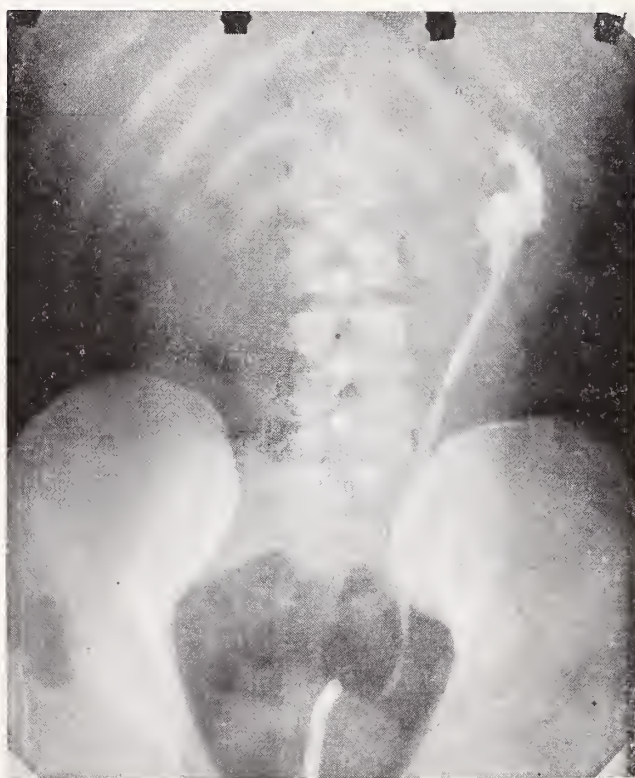


FIGURE 10

There is absence of kidney shadow on the right side. The left kidney is large. There is a congenital variation of the pelvis and ureter

### III. B. ANOMALIES OF THE KIDNEY AS TO FORM

Unless diseased or unless they produce intractible gastro-intestinal symptoms, this group should be left alone. Three patients were seen in this group; one patient with a horseshoe kidney, one patient with a crossed fused kidney, and one patient with a pelvic fused kidney situated over the sacrum (Figure 11).

### III. C. ANOMALIES OF THE KIDNEY AS TO SIZE

This group of anomalies includes cases of congenital hypoplasia. The hypoplastic kidney is incapable of undergoing compensatory hypertrophy.



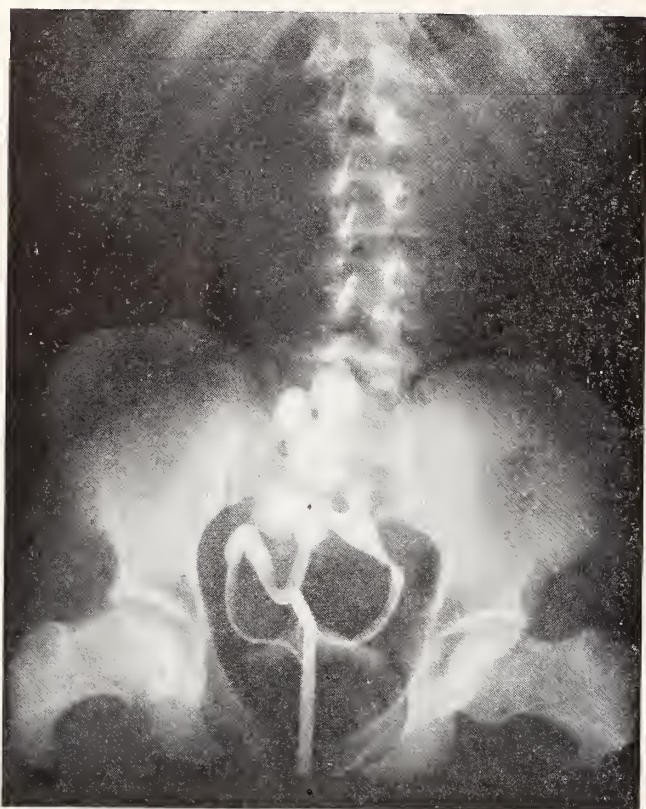


FIGURE 11

Bilateral uretero-pyelograms showing a bilateral fused pelvic kidney with calculi in the right kidney pelvis

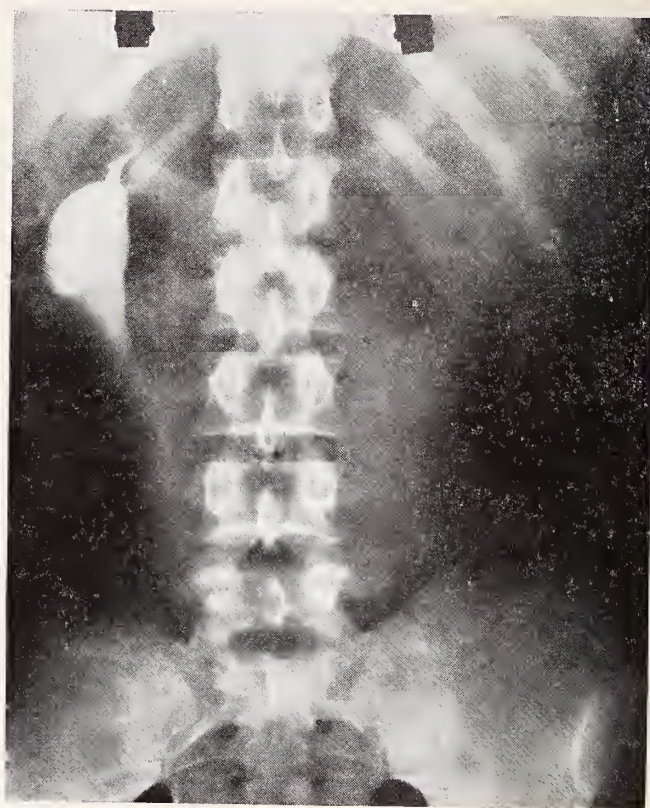


FIGURE 12

Right uretero-pyelogram showing a hypoplastic right kidney with dilatation of the renal pelvis

The pathological changes which occur in these cases are the same as in a normally developed kidney; namely, infection, hydronephrosis and calculus formation. Six patients were seen in this group.

*Case 1.* J. E. H., age 20; this patient was admitted on the general surgical section, then seen in consultation. His chief complaint was recurrent attacks of pain in the right lower quadrant of the abdomen of two months' duration. Abdominal examination revealed tenderness in the right lower quadrant of the abdomen. Bladder urine showed the presence of moderate (15-20) pus cells per high power field. Gram stain of the urine sediment and culture revealed the presence of hemolytic staphylococci organisms. Intravenous urogram showed a normal left kidney; right kidney showed findings of hypoplasia and associated hydronephrosis. Cystoscopic examination showed a generalized mild cystitis. Urine from the right kidney contained pus cells. Staphylococci organisms were cultured. Indigo-carminic renal function test was normal for both kidneys. A right uretero-pyelogram revealed a hypoplastic kidney with a dilated pelvis. Patient was treated for urinary infection with penicillin. The

infection cleared; patient was returned to duty (Figure 12).

*Case 2.* U. L. G., age 23, was admitted to this hospital because of a sudden onset of pain in the right upper quadrant of the abdomen, radiating into the right flank posteriorly. An aching pain persisted in the right flank posteriorly for about 5-6 hours. Tenderness was present in the right flank posteriorly. Bladder urine showed many red blood cells per high power field. No bacterial organisms were cultured. Intravenous urogram revealed a minute left kidney with small pelvis and calyces; the right kidney was hypertrophied. Cystoscopic examination showed a moderately congested trigone. No urine appeared from the left ureteral orifice. Indigo-carminic test was normal for the right kidney. No dye was excreted by the left kidney in 20 minutes. Bilateral uretero-pyelograms showed a hypertrophied right kidney and a hypoplastic left kidney (Figure 13).

*Case 3.* E. M. J., age 24. This patient had had recurrent attacks of pain in the left flank for 18 months; in the last two months he had severe burn-





FIGURE 13

Bilateral uretero-pyelograms showing a hypertrophied right kidney and a hypoplastic left kidney

ing with micturition. Tenderness was present in the left flank. Bladder urine was loaded with pus cells; gram stain of the urine sediment and culture revealed *e. coli* organisms. Intravenous urogram revealed a normal right kidney, and a small left

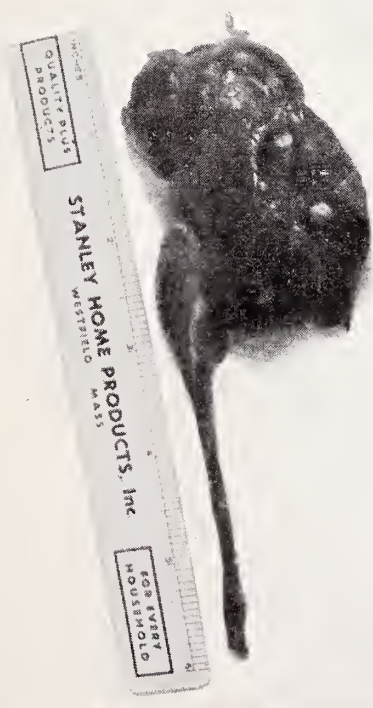


FIGURE 14

Kidney specimen is small in size due to congenital hypoplasia

kidney. Cystoscopic examination revealed no urine coming from the left ureteral orifice. Phenolsuph-nephtalein test for right kidney in fifteen minutes was 25 per cent; no dye was excreted by the left kidney. A left uretero-pyelogram revealed a hypoplastic kidney with a megalo-ureter. A left nephrectomy was performed. The kidney removed measured 6 x 4 x 3 cms. (Figure 14).

### III. D. ANOMALIES OF THE KIDNEY AS TO POSITION

Three cases of ectopia and four cases of malrotation were seen. The symptomatology in these cases depended upon the associated pathological findings.

*Case 1.* Patient R. R., age 19, complained of chronic constipation. Abdominal examination revealed a mass in the right lower quadrant of the abdomen. Intravenous urogram revealed a normal left kidney; the right kidney was overlying the fourth and fifth lumbar vertebrae. Urine from both kidneys was normal. Indigo-carmin renal function was normal for each kidney (Figure 15).



FIGURE 15

Right uretero-pyelogram showing an ectopic right kidney situated over the fourth and fifth lumbar vertebrae

*Case 2.* Patient, D. B., age 45, complained of vague lower abdominal pain. Abdominal examination was





FIGURE 16

Right pyelogram showing an abnormally rotated right kidney

negative. Bladder urine was normal. Cystoscopic examination revealed a normal bladder; urine from both kidneys was normal. Indigo-carmin renal function was normal for each kidney. A right ureteropyelogram revealed a malrotated right kidney (Figure 16).

#### IV. CONGENITAL ANOMALIES OF THE BLADDER

This anomaly is rare in proportion to anomalies of the other parts of the genito-urinary tract. Two cases of diverticulum of the bladder were seen.

#### V. ANOMALIES OF THE GENITALIA

Seven cases of anomalies of the penis were seen. Six of these were penile type of hypospadias with the urethral opening in the mid-portion of the penis; the seventh patient had a peno-scrotal type of hypospadias, with associated bilateral undescended testicles. The testicles were situated in the inguinal canals.

Twelve cases with undescended testicles were encountered, eleven of which were cryptorchidism and one a case of ectopia. Orchidectomy was performed in four of these cases; a two stage Torek orchidopexy in two; five cases were not operated upon since they were intra-abdominal cryptorchidism.

## ADEQUATE CARE OF THE CHRONICALLY ILL

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ORGANIZATION of adequate care of the chronically ill is a problem that is receiving much attention by public and nongovernmental health and welfare agencies. The reason for this growing interest is anything but mysterious. The increase in life expectancy, resulting from the disappearance or marked decline in the incidence and severity of many diseases, and the change in the age of distribution of the population, characterized by the constant growth in the number and proportion of people over 65

years of age, have accentuated a problem of long standing. The health, social, economic, and political questions involved are stirring more and more communities to action.

In many publications on the subject reference is made to "our obligations toward the aged and the chronically ill." Such general statements lend themselves to misinterpretation. It is imperative to make a clear distinction between the old and the chronically ill. There may be debates about the validity of the old saying "senectus ipsa morbus" (senescence as such is sickness) but there can be no doubt that the numerical and proportional increase in the number of older persons will bring with it more—and

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prolonged—physical and mental illness related to advancing years. In addition, many of the aged will be plagued with exacerbations of old chronic conditions or contract acute illnesses that are posing problems because of the age of the patients. Yet, it must be borne in mind that chronic illness occurs in all age groups. This fact has been brought out by countless studies, in particular the study of chronic illness in New York City<sup>1</sup> and the National Health Survey,<sup>2</sup> and it is substantiated by the experience of the Vocational Rehabilitation Service. To identify chronic illness with old age is to confuse the issue.

#### THE NEEDS

Organized programs of adequate care of the chronically ill are necessary in the interest of the patients, the members of the various health professions, the general and mental hospitals, and the community as a whole.

The chronically ill patient needs many professional and institutional services quite different from those required by the acutely sick. What is even more important, prolonged illness constitutes a serious economic burden. Sooner or later it lowers the standard of living of the patient and his family, exhausts their financial resources, makes the sick dependent on the aid of public or private agencies, and saddles his family with debts for years to come. Chronic illness is one of the major reasons why every year thousands of families are "fast rising from affluence to poverty," to paraphrase Mark Twain. Poor housing in general and crowding in particular, lack of family members or other persons who can devote some time to the care of the patient, lack of money to maintain the patient in his own home, and broken homes are factors increasing the demand for care in institutions which offer at least shelter, food, and helping hands. Some authors have remarked that the family no longer clings to the fireside and therefore finds it inconvenient to have an elderly person about the house; that one mother can raise six children but six children cannot provide for one parent. Such assertions are open to some doubt. Many families would be ready to take care of their less seriously incapacitated family members if they only had the space, the time, the money, or the help.

The general practitioner is often called for diseases and disabilities differing in character, incidence, and duration from those usually seen in the past. His ingenuity in suggesting a suitable treatment plan is taxed to the utmost, not so much because of the type of illnesses and impairments as because of their

economic and psychological aspects. All too often the conscientious general practitioner carries a heavy burden in giving freely of his time and money to help patients with chronic conditions. Certain specialists, primarily cardiologists, roentgenologists, psychiatrists, and tumor specialists, are confronted with a mounting demand for service to older people and can expect to be consulted by them much more frequently in the future, despite and because of the emergence of the new specialty of geriatrics.

Many general hospitals report at least one-tenth and, at times, one-fifth of all beds occupied by chronically ill persons who do not require the full service available. The hospital designed, equipped, staffed, and operated primarily to serve patients with acute illnesses continues to be used as a refuge for many sick persons who are admitted and readmitted frequently and stay unnecessarily long because of the lack of adequate housing, resources, and close relatives, the inadequacy of public assistance, and the deficiencies of public medical care.

The city, county, and state hospitals are the main victims of the failure to provide for the necessary special facilities. Many are the "catchalls" for all sorts of conditions, since most of the voluntary general hospitals accept primarily patients with acute illnesses and often only those with a certain type of disease. The task of relieving general hospitals of all patients not requiring the complex and expensive diagnostic and therapeutic services is becoming of paramount importance at a time when rapidly extending health insurance plans and public medical care programs make hospitalization readily available to tens of millions of Americans.

Much like the general hospitals the special facilities for patients with mental deviations cannot be properly utilized for their very purposes. Patients with mental disorders related to advancing years are admitted in growing numbers and, in many instances, have come to constitute a substantial fraction of the mental hospital population. There is much reason to doubt that the modern mental hospital with its specialized services, so urgently needed for treatment, is the appropriate place for the institutional care of patients with senile disorders, and there is justification for the question whether family care could not take the place of institutional care in a good many cases.

From the community point of view four facts deserve special mention. Chronic illness causes staggering losses in man and woman power, wages, and



tax revenues. It results in lengthening relief rolls and mounting expenditures for the maintenance of the seriously disabled, burdens the productive age group heavily, and will continue to tax the resources of the community until the old-age insurance program can make its full contribution and disability insurance is added to the Social Security Act. Some governmental agencies are ready to allot tax funds for additional beds in general hospitals but are unwilling to make expenditures for the construction of complementary facilities, such as chronic disease hospitals, although these specialized facilities are less expensive to build and operate and can free a good many beds in general hospitals. Last but not least, the clause of the Social Security Act that prohibits payment of cash allowances to recipients of old-age assistance residing in public institutions prevents public agencies from adopting a sound policy in regard to the institutional care of chronically ill persons.

#### PUBLIC POLICY IN THE PAST

In the past, official agencies concentrated their efforts on the development of specialized facilities and services for patients with mental deviations, tuberculosis, and serious crippling conditions; they were adamant to the need for adequate, humane, and economical care of other groups of patients with long drawn-out maladies. This was so because fear played a major role in shaping public policy. The services for patients whose illness was not contagious or whose condition did not endanger others were improved only when a scandal of major proportions awakened public agencies to the need for drastic reforms. Among the factors responsible for the reluctance to establish a constructive program three appear to be particularly important: The significance of "chronic care" as essential part of a well rounded treatment plan, medical and social, has been little understood. The possibilities of an effective and economical approach to the problems involved have been badly underrated. The necessary differentiation of facilities and services according to the requirements of the various patient groups has been hampered by a considerable confusion over the meaning of the terms "convalescence" and "chronic illness," and, consequently, over the types of care best fitted to the diversity of situations arising from many different conditions.

Until recently, in the majority of all communities the public policy in regard to services for the chronically ill was as unsound as it was simple.

Hospitalization in general and mental hospitals was granted liberally despite the admitted inadequacy of such practices. Care in custodial institutions was provided reluctantly, haphazardly, and without noticeable effort to establish and maintain reasonable standards of health and well-being. Such service as was available was confined to the needy. In the absence of something better those chronically ill patients who were poor and not too much incapacitated usually were accommodated in the almshouse, that monument to degradation, or in a substandard private nursing home, that monument to neglect. With a few noteworthy exceptions the institutions of the custodial type still are distinguished by shocking defects in physical facilities, nursing, medical attention, nutrition, social service, and occupational and recreational services. Nearly all fail to pay attention to the "famine of the mind." The patients have too many people to talk about and too few friends to talk to. Some of these institutions resemble a glorified jail, and some give the visitor the impression of a dumping ground for human misery. Small wonder that the atmosphere of the institution, no matter how inviting its name, deters self-respecting citizens, and that application for care has come to be regarded as the last resort. To admit that the services for the chronically ill are poor because they are for the poor is to accept as valid the spirit of the seventeenth century Poor Law.

Although few public agencies were indulging in the pleasant daydream that they had done their duty to both the chronically ill and the community as a whole, it has been only in recent years that a new course of public policy became apparent. Credit for this change is due to a few physicians, especially Drs. Ernst P. Boas<sup>3</sup> and E. M. Bluestone<sup>4</sup> of New York, who have been fighting tirelessly for both better understanding of the problem and adoption of sound programs; to Miss Mary C. Jarrett,<sup>1</sup> whose exhaustive study of chronic illness in New York City contributed greatly to our knowledge; and to the American Hospital Association and American Public Welfare Association<sup>5</sup> which made determined efforts to pave the way for the adoption of sound policies and procedures.

#### FUTURE POLICY

How large is the problem at present? Reliable figures are lacking, although the findings of the National Health Survey<sup>2</sup> and the recent studies made in Essex County, N. J.,<sup>6</sup> in a few cities such as Cleveland, Ohio,<sup>7</sup> and St. Paul, Minn.,<sup>8</sup> and in some states,

such as Alabama,<sup>9</sup> Maryland,<sup>10</sup> and New Jersey,<sup>11</sup> may serve as a guide. It cannot be stated often enough that progress in scientific medicine and therapeutic methods as well as development of programs of complete medical care will go far toward reducing the number of persons with chronic illness and the severity of many prolonged illnesses. On the other hand, the increase in the average span of life is certain to continue and, consequently, the proportion of people over 65 years of age will grow larger, reaching, if not exceeding, 10 per cent of the total population.

In charting the future course of public policy the most important step is to formulate an over-all plan providing for all the facilities and services needed to meet the individual's requirements as well as the community's need for adequate, humane, and economical care. The narrow-gauge railway to the custodial institution does not lead to a desirable station and "a label on bricks and mortar does not mean a magical solution of the problem," as Dr. Herman L. Kretschmer<sup>12</sup> has pointed out.

The term "care of the chronically ill" often is used as though it denoted a single entity and implied service for conditions with common cause and similar manifestations amenable to a more or less standardized management. Such is not the case. The needs of various groups of chronically ill persons differ fundamentally. Dr. Herman L. Kretschmer<sup>12</sup> distinguishes "between persons who suffer from chronic illness and who are working every day and those who are suffering from a chronic illness that is disabling." This classification requires amplification. For practical purposes distinctions must be made according to age, type of disease or defect, degree of disability, and mental capacity and temperament—the degree of inability to follow the daily routine of the average healthy person being the important yardstick. Such classification has been suggested repeatedly abroad as well as in this country. Of the more recent proposals those of the Joint Committee of the American Hospital Association and American Public Welfare Association and of the Maryland Planning Commission appear particularly valuable.

The Joint Committee of the American Hospital Association and American Public Welfare Association suggests the following classification:

- (1) persons in need of active and continuous treatment by a physician;
- (2) persons who need chiefly skilled care by a trained nurse;
- (3) persons who require only care by practical nurses or

attendants, with medical and nursing supervision (so called "custodial care").<sup>13</sup>

The publication *Medical Care in the Counties of Maryland* distinguishes five categories of chronically ill persons:

- Those capable of self support;
- Those disabled to the extent that they need boarding-home care with occasional medical supervision;
- Those sufficiently handicapped to require infirmary care with nursing attendance and regular medical supervision;
- Those who are bedridden and require chronic hospital care;
- Those who require the type of medical care which can be given only in a general hospital.<sup>14</sup>

What, then, are the components of an over-all program of adequate care of the chronically ill? They may be described as follows:

1. General services designed to minimize the incidence and severity of chronic illness;
2. Special services designed to meet the needs of persons with chronic illnesses and permanent impairments, including
  - (1) diagnostic clinic services;
  - (2) chronic disease hospitals;
  - (3) infirmaries in homes for the old as well as small home-like facilities with nursing service;
  - (4) physician's services in the home, office, clinic, hospital, and custodial institution;
  - (5) dental services in the office, clinic, hospital, and custodial institution;
  - (6) home nursing and visiting housekeeping service;
  - (7) medical social service in the clinic, hospital, custodial institution, and all administrative agencies concerned;
  - (8) essential drugs and appliances;
  - (9) occupational therapy and recreational services;
  - (10) provisions for economic security of disabled persons.
3. Intensive research on problems of chronic illness, including socio-economic and psychological as well as clinical aspects;
4. Postgraduate professional education in the diagnosis and treatment and in the socio-economic and psychological aspects of chronic illness.

Details cannot be discussed here. A few comments, however, will serve to bring out the complexity of the problem.

Education in the principles of healthful living and the full and discriminating use of available services is regarded as basic. This nobody will dispute. But



preaching a doctrine is one thing and providing for opportunity to heed the expert's advice quite another. Health education intensifies the demand for good medical care—the farther health education progresses, the greater the need for removal of the economic barrier between those ready to render service and those anxious to obtain it.

A general program of medical care for all the people, with emphasis on early diagnosis and early and thorough treatment of high quality, is the logical basis for concerted action against chronic illness. To limit plans to the development of specialized services for the chronically ill is to start from the tail end. Such policy is a stopgap, trying to meet needs by taking care of end-results of diseases and residual stages of serious illnesses; it does not go to the roots of the problem.

Diagnostic clinic service is the heart and center of the program. It is of special importance for the diagnosis of conditions lumped together as “arthritic,” of cardio-vascular diseases, mental deviations, and malignant tumors. If properly organized, staffed, and operated the clinic, whether private or public, affords an unparalleled opportunity not only to establish a correct diagnosis at the earliest possible moment but to carry out the arduous and time-consuming follow-up work.

Well organized visiting nurse service can go far toward meeting the needs of those patients with chronic conditions who are not seriously incapacitated and toward preventing a certain number of admissions to institutions. Encouragement should be given to the wide use of practical nurses and nurses' aides, working under the direction and supervision of graduate nurses, and of visiting housekeepers. As ample experience has shown, well organized housekeeping service benefits the patient and his family, the health professions, and the community. The effectiveness of home nursing programs integrating the services of graduate nurses, practical nurses, nurses' aides, and visiting housekeepers, depends on the availability of organized home medical care; proper selection, intelligent assignment, and close supervision of auxiliary personnel; and coordination of the nursing program with other health and welfare services, official and voluntary.

The need for chronic disease hospitals is undisputed. Adequate chronic disease hospitals cost less to construct and maintain than general hospitals. The construction costs depend upon the land value, type of organization of the hospital, and equipment;

they may be as low as one half of the costs of a general hospital of high standards. The operating costs of chronic disease hospitals are influenced by the type of diseases; the ratio of trained personnel to patients; amount of special equipment; the provisions for special diets, physical therapy, occupational therapy and recreational services; and the patient turnover. The economies attainable may be substantial, the costs of a patient day amounting to three-fifths of those in high grade general hospitals. Dr. Wilson G. Smillie<sup>15</sup> has given a useful comparison of the requirements of acutely sick and chronically sick patients needing hospital care. Wisely, the Hill-Burton bill (S191) recommends for chronic disease hospitals a bed rate not in excess of 2 per 1,000 population.

The bone of contention is the method of organizing hospital services for the chronically ill. One school of thought favors the “integrated acute-chronic hospital plan” under which sections of the general hospital or special units on its grounds would be set aside for the chronic sick. This method of organization, it is argued, would facilitate the initial and final assignment of the new patient, his easy transfer when needed, full utilization of already available resources in equipment and specialized personnel, economical administration of all services, and easy contact between the sick and his family and friends. An integrated social, medical, educational, and research plan would have moral and scientific value and serve to avoid “the ‘dumping’ process by which undesirable patients are transferred from general hospitals to public institutions of less satisfactory qualifications.”

Admitting the feasibility of such a plan in certain cities, a second school of thought nevertheless believes that separate chronic disease hospitals offer considerable advantages. They could be built and operated less like acute hospitals and, thereby, give the chronic patient the special consideration, comfort, psychological atmosphere, occupational services, and recreational facilities he has to forego on a special ward or in a special pavilion of a general hospital. They could be staffed with personnel giving their full interest and time to the task, and develop into research and teaching centers on medical, psychological, and socio-economic problems of chronic illness. They would prevent inadequate care in small facilities by serving a region rather than a political unit with small population and be less expensive to build as they could be erected outside densely popu-



lated areas. In this age of rapid transportation, facilities located at a distance from the centers of population would be easily accessible. Actually both methods of organization have been employed, although only sporadically.<sup>16</sup> Pertinent details of the art of operating facilities for the chronically ill are described in a series of articles in the journal *Modern Hospital*.<sup>17</sup>

Regardless of the method of organization, the facility for patients with chronic illnesses must have a resident staff of physicians and dentists. Determined efforts must be made to attract competent professional men and women, difficult as this may be. Buildings without brains are of little avail. At the risk of laboring the obvious it must be stated that a chronic disease hospital built at the expense of all should be operated for the benefit of all, the charges to be determined according to ability to pay. This suggestion can come as a shock only to those clinging to the tradition of the Elizabethan Poor Law of 1601. Restriction of admission to the needy would mean neglect of the needs of self-supporting people, creation of a poor-house atmosphere, and waste of taxpayers' money. Chronic illness sooner or later brings poverty. Poverty begets illness and contributes to the duration and severity of chronic illness. To maintain hospitals only for those sick who have exhausted their own resources is contrary to the principle of preventing dependency.

It is gratifying to notice that some communities are planning to admit to chronic disease hospitals any patient needing such service, regardless of his economic conditions.

Reluctant to commit themselves to the erection of a functional building some public agencies have focused their interest on the conversion of an existing almshouse into a chronic disease hospital. The realization of such a project is beset with difficulties. The majority of these institutions would require major alterations, and all of them would have to be adapted to their new function by drastic changes in equipment, personnel, and management, not to mention the fact that their evil reputations could hardly be wiped out in decades.

County homes and similar institutions should be equipped with infirmaries where patients with minor acute illnesses and exacerbations of chronic conditions can receive nursing and medical service. How important this point is can be seen from a recent report on Alabama. An analysis of the almshouse population in that state in September 1944 showed

261 residents in 5 almshouses. Of these, 201 were estimated to be in need of nursing care.<sup>18</sup> In the absence of more details one can only surmise that some of these persons would be helped by an infirmatory service and others by transfer to a chronic disease hospital.

The use of private nursing homes can be recommended only if minimum standards for their operation are set and enforced through licensing and supervision, including regular inspection as to physical plant, equipment, and operation. A pertinent example of this policy are the standards prescribed by the New Jersey State Department of Institutions and Agencies.<sup>19</sup> Approved private nursing homes should receive rates of payment enabling them to maintain reasonable standards of service, and substandard homes should be closed for good.

The organization of the total program should be based on time-tested principles and not on town hall politics. The hospital beds for the chronically ill should be concentrated in larger units rather than being dispersed in small facilities, with multi-county or district organization receiving preference wherever feasible. All other services should be decentralized to be in close proximity to the patients to be served. The specialized program should be integrated with all other health and welfare services.

Public responsibility should be assumed for both the formulation of the plan and the establishment and operation of the service, as these functions cannot be performed by voluntary agencies. In line with the practices adopted in many other fields of health service, state agencies should be vested with responsibility for policy making, construction and operation of chronic disease hospitals, assistance to local agencies, and general supervision of the total program. Local agencies should have administrative responsibility for all services they provide and share in the costs of care of their own residents in state owned institutions. In some foreign countries, such as Sweden, the national governments have long granted subsidies for the construction of chronic disease hospitals. A similar policy is proposed in the Hill-Burton bill (S191) now pending in Congress. This measure includes chronic disease hospitals in the list of facilities to be constructed with the help of federal grants-in-aid. If enacted, this bill will at long last fill a serious gap in the hospital programs of the vast majority of the states.

To hope that the building of chronic disease hospitals will solve the major problems involved would

mean to escape from reality. The hard, cold fact is that organization of payment for professional services inside and outside the hospitals and for the services of hospitals as well as custodial institutions is as important as construction of new facilities.

The value of special services for the chronically ill cannot be questioned. But there is good reason to doubt<sup>20</sup> that such a program can function effectively and economically in the absence of complete medical care for all the people—the logical starting point for concerted action against the “unseen plague—chronic disease.”

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## A COMMENTATOR'S VIEW OF THE MEDICAL DILEMMA

UPTON CLOSE, *Hollywood, California*

IT IS A great honor to me to be invited to lead off a discussion with you. I am going to do it in the spirit of a forum. You know a lot more about the answers than I do.

I am going to give you what is the essence of a little look I have had into the Wagner-Murray-Dingell bill and the forces that lie behind it. I found myself getting into what seemed to be just the very inside of the real plan to substitute state Socialism for the American system of enterprise and government.

I wondered first of all why the stateists pick you doctors as the soft spot for the entering wedge. Why didn't they pick the lawyers? Why didn't they use them as their cutting edge of the wedge to get into the professions? They chose to let the lawyers alone. Lawyers are pretty tough. They are a little more worldly wise. Then it seemed to me there were other reasons perhaps. Under the word “stateists” I group the state socialists of all types from the well meaning “do-gooder” who calls himself a Christian Socialist, to the completely ruthless



full-out Marxist who believes in revolution by force, the abolition of all standards of what we have known as honesty, ethics and truth, and the use of any form of lying and misrepresentation and taking advantage of his victim's basic honesty in order to undo him. Our stateists very carefully survey the field before they move. I find that their move on medicine is nothing new. It has been under preparation for a very long time. The first bill prepared under the title of Wagner-Murray-Dingell was back in 1943. In 1944, Mrs. Eleanor Roosevelt came out in favor of this idea. In 1944 and 1945, the labor unions began getting behind it, first the CIO and eventually the A. F. of L. leaders. Then, when the ground had been very well prepared, a whole flock of bills which have associated with them the names of Wagner, Murray, Dingell, or Pepper, appeared in Congress. One of those bills was passed by the House only the other day. Probably you didn't even notice it. It was slipped through in a hurry, a ten million dollar grant for psycho-neurotic clinics. Some medical men favor these grants-in-aid so long as they are administered by the local authorities. I think that is a question which deserves a good deal of consideration and discussion.

How far will the medical profession and individual doctors want to go in favor of these grants-in-aid? You may be sure that the people who are trying to set them up, good as they may be in principle, are the same people who are behind the over-all bill for state medicine—exactly the same people. Their aim in both cases is the same. The grants-in-aid scheme is probably, from their point of view, a greasing of the wedge they are going to put in. Undoubtedly they intend that these grants-in-aid shall fall under the administration of people of their own stripe. I don't know what is going to happen to ten million dollars for psycho-neurotic clinics provided the present bill gets through the Senate, but you can imagine that it might fall into the hands of a number of young professors, each one setting out to use some of the government's money to test out his own particular theories on a bunch of poor guinea pigs who happen to come under his control.

There is a whole flock of bills, all of them put out by this same group, designed to hammer away on a number of different fronts. One of them concerns the problem child—the so-called Pepper bill. It is disguised as a medical bill. It is not a medical bill; it is a bill to give the state or its social workers control over a certain proportion, or maybe *all*, of

the youth of America under the guise of their need of medical attention. Under that bill, if it should pass as I read it, anybody could go to the local authorities and claim that Johnny Jones was not being properly raised by his father or his mother, and soon Johnny Jones would be under the control of the state, and his parents would have lost control of their own child.

Now, the first thing that strikes a layman in studying this whole measure is that none of these bills originated with medical men. I can't find any evidence that a single one of them originated with the medical profession or even from laymen who are particularly concerned with the health of the nation's people. These bills originated from politicians, not from medical men. They were drafted in their present forms, which are just about the worst conglomeration of vagueness and double meaning any one could possibly get into the English language, by fifty-odd specialists in the Department of Social Security. When the hearings were held on the bills in Washington, I am told, these men passed back and forth between their own files in the Social Security Administrative offices and the Senate offices where the hearings were being held, carrying with them huge quantities of material, files of one kind and another. They engaged in rude interruptions during the testimony; they acted as if they considered themselves part of the investigating committee—which in effect they were, of course.

Now the question boils down to this in my mind: Is this whole effort to institute state medicine and all of the specific presentation of it something coming from men whose profession is to be concerned with the health of the nation and something which, therefore, is intended to benefit the health of the nation? Or is this effort originating from men with a political purpose who aren't primarily concerned with the health or welfare of the nation at all, but who are merely taking advantage of an opportunity that exists, perhaps, because of resentment and dissatisfaction with the cost of medical attention and hospitalization? The question of whether the motivation is political or whether it is the welfare of the public and the individual should be highlighted to the American public with a thousand times as much candlepower as it has had.

I have often wondered just how the medical profession regards itself, anyhow. I was trying to get myself boned up on some figures. I found a lot of conflicting figures as to what the investment of

young men in your profession amounts to. Take just the 125,000 odd members of the American Medical Association. (I believe there are 70,000 or 80,000 others recognized as M.D.'s) But considering the 125,000 A.M.A. members—suppose their education cost them \$25,000 each. I should think that would be a conservative figure, wouldn't it? Suppose their equipment, when they get into practice, is worth \$15,000 each. That is a \$40,000 investment. That means five billion dollars of capital invested in the medical profession, just for training and equipment? A firm in the business of putting up electrical wires would say—what does it cost to provide service? What is the capital investment? If you are going to figure a 6 per cent interest on your capital investment, it amounts to three hundred million dollars a year, or \$2,400 for each of the 125,000. Now I saw in a statement from the A.M.A. that the average income of the doctor was \$5,000. Twenty-four hundred dollars of this is just interest on capital investment! That leaves him on the average, about \$2,600 actual earnings for the year. Something is wrong! I don't know what it is, but I don't believe men of your caliber should be working for me or anybody else for \$2,600 a year!

I have read from government figures used by these social welfare workers, that six or seven billion dollars a year is spent by the American public and government now on public health. Who is getting it? If the doctor is making an average of \$5,000 a year, he is certainly getting a very small cut of the amount being spent on public health, isn't he? The doctors, according to these figures, get only six hundred and twenty-five million out of seven billion spent annually.

Yet the doctor is getting most of the blame for the cost of people's sickness. Apparently a very, very small proportion of money spent on ill health goes to the doctors. The bulk must be going to hospitals and for medicine. I don't know where else it is going. It seems to me that these figures ought to be cleared up in the minds of the public before they are asked to decide whether the doctor is going to be made an agent of the government, and his freedom to practice as he wishes taken away from him.

I have a lot of other questions I could ask, but they add up to the fact that it seems to me that M.D.'s are taking about as poor care of themselves as any group of professional men or workers in the country. This is a day when we have to take group care of ourselves or just get trampled under. This

is a day when it is recognized as politically and morally ethical for shipworkers or streetcar workers or anyone else to strike and quit work if they don't like the conditions. Our present government endorses the right to strike regardless of the public's discomfort because of it. And yet, here is a group of men representing an investment of five billion dollars who allow themselves to be badgered and told by some officials in Washington that it is very wrong and wicked for them to talk about refusing to work under conditions which may be arbitrarily imposed on them. I don't know any professional men or laborers in any other walk of life who are going to work under conditions that they regard as slavery, and I think that the public at large is not going to have much respect for the men of any profession who let themselves be badgered that way. I think the public would have far more respect for doctors if they would say: "The streetcar worker strikes against you whether you are sick or not, whether you are crippled or not, or whether you will starve without transportation to the job or not. We are not going that far. We are not going to strike against the public. We are going to continue to offer our services to sick people on exactly the same terms as before, but we are going to refuse to work for and under an administration arbitrarily set up over us, one that we have not willingly accepted." As an outsider, it seems to me this would kill the whole project, the whole political project of enslaving the medical profession and making it part of state bureaucracy.

You know that all of the things that have been promised to the patient in these pending bills are proved untrue. They are proved untrue now in Germany. They are proved untrue in England. Right now they are being proved untrue in New Zealand where there is a movement to turn medicine back to the individual doctor after the state has emptied its treasury on it. You know the fallacies in the presentation that people get better and cheaper medical care if the state, if the politicians, control it. These untrue statements should be made much plainer to the common people in America, and you are doing us a disservice by not reaching them and telling them these things. The enemy is filling them full of this stuff. Every day seven or eight broadcasters over the networks are feeding it out because their hearts are in the socialistic scheme. How many broadcasters have you got feeding out to those same audiences the correction of these lies? That is



a job of public relations and it is also a job of self preservation.

So, here is a profession representing a huge investment (an investment necessary for the welfare of the people) which certainly ought to be in an organized form exercising its rights to say what kind of conditions they will work under—just as General Motors management says what kind of conditions it will work under and what kind it will close shop under; just as the employees of General Motors say what kind of conditions they will work under and what kind they will close shop under. If the medical profession would do that, the scheme of the politicians for using you as the soft and sappy part of the American body politic into which they can drive their wedge of socialism would be deadlier than a dodo. Right then and there it would die, because you can't have socialized medicine without doctors. Why fool around? The men who are against you are very powerful. They don't care about your investment. They don't care about the public's health, really. They are the same kind of men who put over Communism in Russia, and they put it over even though they had to kill twenty million people to do it.

There is one thing you doctors have to recognize, and that is, you have a Trojan horse inside your ranks. I have run into him, I have been bitten by him, kicked by him, several times already. There are non doctors in charge of some of your organizations, who help to hold you in leash, by telling you that you cannot ethically take a stand in your own protection. You medical men must be the judges of your own ethics. Remember that Marxists make a boasted policy of trapping honest men through their own ethics.

I feel that developments on the voluntary basis are the finest counter to the despotic basis: such magnificent beginnings as Dr. Brunk's Michigan plan. Yet this can have certain forces inside it trying in every way possible to bring state medicine. Gentlemen from these forces may happen to be on the board of this, that, or the other voluntary plan, and they are going to block any scheme for getting to the public with the true objections to that plan. If the wishes of these gentlemen are going to be honored, then, my friends, you are sunk. You are finished, because these gentlemen who comprise the 10 per cent Trojan horse among you, know what they want. What they want is to regiment

you under state officers, and they are going to stop anything that hinders that development. They are going to stay in your organizations pretending they are of you, but stabbing you in the back. They are going to be in there working, and if 10 per cent can block the wishes of 90 per cent to fight state medicine, then you are going to have state medicine!

Now it seems to me there is one other angle of public relations that doctors need help on. You know, the doctor is like the commentator. People write nasty notes to the commentator because they don't like him. The doctor is likely to get the idea that everybody loves him. Well, a lot of people do love him and, perhaps, personally and individually, everybody loves him. But the public doesn't love the medical profession, I am sorry to say. It seems to me that a lot of study should be given to the reasons for that. I wonder why the A.M.A. and groups of that sort do not set up very careful committees to study the question of what complaints the public has against the medical profession which are being formed into a crusade to put over state medicine. I have had a lot of experience with M.D.'s. I have often been ill in tropical countries. I was trying to think what it is that I have in *my* heart against doctors. Well, for one thing, absolute bafflement! I go to six or eight doctors, maybe, about the same lot of symptoms, and I get six or eight different diagnoses, and I wonder, are they just guessing?

I realize that it is difficult for doctors to deal with the public today because so many patients are psychoneurotic when they go to the doctor's office. If the doctors tell them the trouble is in their heads, they get mad at the doctor, and if he tries to give them something to cure them that doesn't work, they get mad at him just the same. So there it is. But if there is any way to eliminate this bafflement of the public, it would be of great use to the profession. Again, you run into cases where over-specialization seems to be the trouble. It might be that there was a failure on the part of a gynecologist and a urologist to get a proper diagnosis of a case. So each one went ahead treating what he saw, and there was a terrible expense and long months in the hospital. All that will be laid at the doctor's door. Well, maybe there is a way to get more general supervision over the specialist for the sake of the poor guy who comes in and doesn't know what is wrong with him or his wife. I don't know. That is your problem.

Then again, I have heard complaints that the rich

man is all right; he can afford it. The poor man gets wonderful public care by good and charitable doctors. But the middle class man is paying the bills, is paying more than he can afford. These complaints are taken advantage of by the people who want to introduce state medicine. It might be possible to rectify to some extent these difficulties, but above all, it is possible for doctors to go out and tell their story to the public and get its sympathetic ear. If the story about the difficulty a doctor meets because of the psychoneurotic condition of so many patients were told to radio audiences, for instance, the public would say: "He is doing the best he can, and if state medicine came in, he couldn't do any better—might even be hampered."

I am convinced that the ultimate and best defense against state medicine is the voluntary medical insurance plan. I don't understand the distinction between non profit plans and profit plans. I suppose the doctor has to get paid in any case, and I think he should be properly paid. I think he should be much better paid than was suggested a week or so ago that he be paid in England. I notice that under the new English plan a doctor would start with not less than \$2,000 a year, and by the time he is fifty years old, he will be earning \$10,000 a year. That is state medicine for you, and no wonder the British doctors are beginning to rebel and are signing a pledge that they won't work under it. The doctors have to be paid in any case, and if there is a selling service, that has to be paid for, too.

I don't know what you mean by profit or non profit, but the very best way to combat state medicine is to go out and sell the people something

better. Tell them why it is better, tell them it is voluntary, it is in accord with American traditions. The other thing is not American, it is Communistic, it is Marxist. Show them what they get for money they put in. Tell them that if they want medical care, here is a way they can buy it just as they pay for their life insurance. It won't be taken out of their wages by their boss, under the direction of a tax collector! *Sell* them something.

In other words, I think a great job of public relations is needed. Start fighting! You are going to find such organizations as CIO-PAC, the social workers and the "do-gooders," the Communists and the half-Communists and the "pinkos"—you are going to find them too much for you unless you get out and fight. First of all, tell them pointblank and in an organized fashion—and enough of you to make it count—that you won't work for them. The public would applaud that! And cut out this nonsense that you aren't allowed to say anything in your own defense. Secondly, there are problems and difficulties with your patients. They go around complaining; well, why don't the doctors do some nice complaining about patients? Turn the tables; ask them for their understanding; tell them what a doctor is up against. And thirdly, sell them something better in place of state medicine. There is no use being reticent about it. Buy radio time and get out and sell it for the simple good of the people. If you let them know it is there, they can buy it if they want to. If you sell what you have, I don't think the Wagner-Murray-Dingell bill will have much popular support.



# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### Graduate Education in Connecticut

The advance of medical science is such that a physician's training never ceases. In this doctors are not unlike the nephews of Mary Moody Emerson, who, when asked about their progress, replied: "Sir, they were born to be educated."

There has been a considerable emphasis on the subject of graduate education for physicians since the close of the war, brought about largely through the desire for such training on the part of physicians returned from military service. In many places so-called refresher courses have been set up with a view to giving this type of education in concentrated doses over a relatively short period. Undoubtedly, such courses have been of value, although in our own State the need for programs of this nature has not been acutely manifest. One reason for this may be found in the many opportunities which are open to Connecticut doctors, not only in the many regular medical society meetings but in numerous other activities, such as staff meetings, tumor conferences, and clinical pathology conferences.

Our most concerted effort in education at the graduate level for Connecticut physicians is seen in the Clinical Congress, the success of which is truly measured in the high yearly attendance. The greatest single factor in the success of this undertaking has been the time and effort that is put forth each year by those associated with the Yale School of Medicine, who arrange the program in all of its

many details and share to a large extent in its teaching exercises. For many years the School of Medicine has also interested itself in extending its undergraduate teaching program for the benefit of practicing physicians. During the school year many conferences and clinics are held at which physicians are welcome. In this issue will be found a list of these conferences, which should prove useful to all those who are interested in taking advantage of the many opportunities which are so offered.

### Rhode Island Raises State Dues

By an action of the House of Delegates the Rhode Island Medical Society has raised the annual assessment for members to \$40 for the year 1947. The report of the Budget Committee points out that as a non profit organization the society is not constituted to accumulate sizeable reserves which are needed to retain and add to the staff of employees of the society and also states, "The increasing expansion of the Society as a vital organization in the State, and its supervision and participation in various activities within and outside the Society has placed a tremendous burden upon the executive office. The committee proposes that additional help be provided as needed for the better protection of the public and the profession in the ever widening sphere of governmental, and other programs involving medical, hospital and public health care."

In our own state we should recognize our good fortune in being able to keep our assessment at its

relatively low level, but we should not forget that with our larger membership our financial problems are somewhat different. Nevertheless, we must be grateful to those who are doing such a fine job in the regulation of our finances. It may be that in the future as our Society finds necessity for expansion of activities we shall be faced with problems similar to those of our sister society. When that time comes a modest increase in our own assessment may be necessary. To those who are familiar with the high degree of efficiency with which our affairs are now being conducted such action will not seem unreasonable.

### Twenty-Five Years of Insulin

Twenty-five years have elapsed since the discovery of insulin by Banting and Best and not only has the treatment of diabetes been changed completely, but medicine has been given a weapon against one of the major diseases of middle and later life. A recent comment showing the great effectiveness of insulin in the control of diabetes points out the mortality experience of the George F. Baker Clinic in Boston, which shows a reduction of more than 95 per cent at ages under 40, and a reduction of two-thirds among middle aged diabetics, and about half for older diabetics. A major factor in this decline in mortality has been the reduction in deaths from diabetic coma, also the death rate from infections and gangrene has markedly declined. Also, since this important discovery, the number of diabetics in our population has greatly increased. Among factors which have favored this increase is our aging population, the increased use of simple tests for detecting diabetes, and the increase in the periodic and other health examinations, such as those done for life insurance. A recent estimate states that the number of known diabetics has more than doubled in the last 25 years, an increase particularly large in middle life and old age. A statement in the Statistical Bulletin of the Metropolitan Life Insurance Company points out, "In view of this great increase in the number of diabetics, it is only to be expected that the long-term trend of the death rate from diabetes in the general population would be upward, and in fact this is the case even when correction is made for the aging of the population. Thus, among policyholders of the Metropolitan Life Insurance Company, the age-corrected death rate in the five year period 1941 to 1945 was 11 per cent

above the rate for the preinsulin years 1920 to 1922. So marked, however, has been the improvement in the mortality among diabetics that at all ages up to 55 the death rates have actually fallen. The death rates among insured white males at ages under 35 in 1941-1945 were about two-thirds less than the rates for 1920-1922, and the reduction among females at these ages was more than 50 per cent. Only at ages past 55 are the rates for 1941-1945 above those for the preinsulin period." Factors other than insulin have been of special benefit to diabetics. The use of chemotherapy in diabetics suffering from respiratory, surgical, and other infections have been particularly valuable, for the hazard of these complications is well known. Also, better management of the disease has come about through the education of patients and the use of slower acting insulins. Advances in the future will come about through both early discovery of cases and by the education of patients. A nation-wide program for the control of diabetes should follow the lines set down by the tuberculosis program. One of the triumphs of modern medicine is the help and hope that can now be given to those affected with diabetes. The spreading wide of this knowledge by both official and voluntary agencies can have tremendous results.

### Psychotherapy in General Practice

Under this title Geddes Smith of The Commonwealth Fund presents a report of an experimental course held during April of this year at which twenty-five physicians attended the University of Minnesota for two weeks of intensive training. The impetus for the experiment came from a group of military and naval psychiatrists and medical educators who agreed that the care of veterans with psychoneurotic reactions must be given primarily by general physicians and recommended that a pilot course be set up at the post graduate level to explore the possibilities of educating men in practice for this responsibility. The story of this interesting and successful enterprise is set down in the report which is published in booklet form and is available to Connecticut physicians on request from The Connecticut Society for Mental Hygiene, 152 Temple Street, New Haven. The booklet is an attractive presentation of a stimulating experience which offers convincing evidence that psychotherapeutic medicine can and should be a part of postgraduate medical education.



## THE PRESIDENT'S PAGE

**T**HE YEAR nineteen hundred and forty-six has gone into history. The Connecticut State Medical Society can look back on that span, grateful for some occurrences and with pride in some of its own accomplishments.

We are grateful that during the year we welcomed the return of the majority of our brother physicians who served in the Armed Forces. We are proud that in 1946 the membership of the Society reached an all time high. We were happy to complete the purchase of a site for the new permanent home of the Society. Approximately one half of the members have contributed to the Building Fund, and in late months the indications were that the goal will be reached.

We are pleased that arrangements with the Veterans Administration have made it possible that veterans with service-connected disabilities may be treated by their own physicians on a fee basis. What a happy solution to one of the most distressing phases of the last postwar era.

After long years of study and real labor on the part of some of our members the problem of prepaid medical care is being resolved. Following consultation with representatives of Society, certain insurance carriers are now offering Society approved contracts providing for cash benefits for surgical treatment and hospital care in one package on a group basis. Extension of these contracts to include medical treatment and broader coverage will depend upon the results of experience during a trial period. If these plans are successful the professed need for federal compulsory health insurance will be disproved.

Upon the mandate of the House of Delegates the Society has engaged the services of a full time public relations representative. It is not too soon to say that this wise action has resulted in a long forward step in the progress of the Society.

Our JOURNAL, we know, is a splendid periodical. We are proud that it is so recognized and commended nationally. Our representatives in the legislative forum of American medicine are held in high regard throughout the country. Their wisdom and integrity have contributed not only to the welfare of the Connecticut Medical Society but to the broad field of medicine on the national level.

Indeed we may remember 1946 with gratitude and pride. But nineteen hundred and forty-seven is now with us. The problems of its onrushing days will be many and not simple. May there be given to us the strength and the wisdom, and the concert of an integrated Society sufficient to meet and solve these problems. At the dawn of the next new year may we once again be able to look back content in the knowledge of works well and faithfully done.

To every member of the Society I extend my very best wishes for a Bright and Happy New Year.

Cole B. Gibson, M.D.

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## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

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### COMMITTEE ON PUBLIC HEALTH

The Committee on Public Health is designated in the by-laws of the Society as its representative in all matters pertaining to public health, sanitation, the prevention of contagious diseases, maternal and infant welfare. This broad assignment has brought increasing responsibility to the Committee particularly in recent years when several public health programs operating with Federal grants-in-aid have been undertaken by the State Department of Health.

The Emergency Maternity and Infant Care program, which was designed to provide prenatal, obstetrical and pediatric service for the wives and children of enlisted men in the lower grades of the armed forces, was one of the broadest of these projects. It was inaugurated by the United States Children's Bureau without prior consultations on the state level to determine standards or fees. The impossibility of successful operation of this kind of ready made program soon became apparent and the State Bureau of Child Hygiene turned to the Committee on Public Health for assistance. Through the joint efforts of the Bureau and the Committee, standards for specialist consultants were established and fees regulated with the result that the EMIC program in Connecticut has functioned, in view of its intrinsic limitations, with reasonable efficiency.

During the war the Committee was frequently called upon to act in an advisory capacity to various Federal government agencies. It developed uniform procedures for the medical prescription of scarce foods and succeeded in eliminating many of the difficulties inherent in the provision of extra rations for the sick.

The working relationship between the Public Health Committee and the State Department of Health has grown steadily stronger through regular conferences on a variety of problems concerning the health and welfare of our people. The Committee has advised on the operation of well-child conferences and the establishment of standards for conference physicians and has given counsel in the regulation and supervision of maternity hospitals. It has assisted in the development of a plan, financed by Federal funds, to furnish obstetric and pediatric



HOWARD S. COLWELL, M.D.

consultation in small communities for persons unable to pay themselves for such consultations.

Several sub-committees have long been active in handling important special assignments. Dr. Paul P. Swett's Advisory Committee to the Crippled Children's Division of the State Health Department has worked with the Division throughout the establishment and expansion of the crippled children's program. The sub-committee advising on the evaluation



of laboratories performing serodiagnostic test for syphilis has also been called upon frequently.

The Committee on Public Health is presently engaged in giving its support to the establishment of health districts, under the administration of full-time, trained health officers, throughout the state and has recommended a close liaison with the State Department of Health in the attainment of this objective. Upon its recommendation also, the Council has named a new permanent Committee on Maternal Morbidity and Mortality.

Dr. Howard S. Colwell, New Haven, is the chairman of the Public Health Committee and the other members are Donald A. Bristoll, New Britain; John W. Buckley, Bridgeport; Jessie W. Fisher, Middletown; Joseph I. Linde, New Haven; Luther K. Musselman, New Haven; Karl T. Phillips, Putnam; J. Harold Root, Waterbury; Howard G. Stevens, New Milford; Maurice J. Strauss, New Haven; Oliver L. Stringfield, Stamford; Carl L. Thenebe, West Hartford; Carl H. Wies, New London. Associate member: Friend L. Mickle, Hartford.

### December Council Meeting

The regular monthly meeting of the Council was called to order by the Chairman, Dr. Murdock, on Tuesday, December 3, at 4:30 P. M., at 258 Church Street, New Haven. There were present Drs. Murdock, Phillips, Weed, Speight, Miller, Thoms, La-Moure, Weld, Gildersleeve, Gibson, Howard, the secretary, Dr. Barker, and executive assistant, Miss

Mooney. Absent: Drs. Campbell, Moore, Mullins.

The majority of the meeting was devoted to completion of plans and discussion of the agenda for the Semi-Annual Meeting of the House of Delegates on December 30 in New Haven.

### Specialist Standards for Veterans Administration

The agreement between the Society and the United States Veterans Administration developed by the Committee on Medical Care of Veterans and now in force provides that "The Connecticut State Medical Society will assist the Veterans Administration in establishing for examinations and treatments a list of competent specialists who meet the qualifications of specialists of the Veterans Administration."

The Council established the following criteria for qualification as specialists:

- a. Certification by one of the American Specialty Examining Boards.
- b. Eligibility for certification by one of the American Specialty Examining Boards.
- c. Membership in one of the recognized Colleges of Special Medicine.
- d. Membership in recognized societies in special fields of medicine.
- e. Community recognition as a specialist evidenced by holding a responsible appointment as an attending physician on the staff of a recognized hospital.

## THESE GAVE

### CONTRIBUTORS TO THE BUILDING FUND—NOVEMBER 10 TO DECEMBER 10

#### FAIRFIELD COUNTY

Ayres, P. B., Cos Cob  
Dean, S. R., Stamford  
Dichter, C. L., Stamford  
Fine, B., Stamford  
Fine, J., Stamford  
Fiske, M., Stamford  
Henderson, Jean, Stamford  
Hertzberg, R., Stamford  
Hymovich, L., Stamford  
Koffler, A., Stamford  
McGourty, F. C., Stamford  
Miller, H. K., Stamford  
Ogilvie, J. B., Stamford  
O'Meara, F. P., Glenbrook  
Rawls, C., Stamford  
Robison, Roy C., Stamford

#### FAIRFIELD COUNTY—Continued

Shermak, J. V., Old Greenwich  
Sherman S. H., Stamford  
Starrett J. E., Stamford  
Terhune, W. B., and associates  
Silver Hill, New Canaan  
(additional pledge)  
Warner, G. H., Bridgeport  
Washburn, W. J., Stamford

#### MIDDLESEX COUNTY

Schwartz, P. E., Portland  
Whiting, H. St. J., Middletown

#### NEW HAVEN COUNTY

Bayne-Jones, S., New Haven  
Herrmann, A. E., Waterbury  
Stilson, C., New Haven

#### HARTFORD COUNTY

Benoit, R. J., New Britain  
Byrne, D. W., Hartford  
Curtis, B. H., Hartford  
Donner, S., Hartford  
Ellis, F. D., New Britain  
Fay, W. J., Hartford  
January, D. A., Hartford  
(additional pledge)  
Lampson, R. S., Hartford  
Lischner, M. D., Hartford  
Middlebrook, Jr., L. F., Hartford  
Schuman, D. H., Hartford  
Smith, S. L., Hartford  
Snelling, P. W., Hartford  
Unsworth, A. C., Hartford  
Weissenborn, W., Hartford

## New Committee on Maternal Morbidity and Mortality

The Society's Committee on Maternal Morbidity and Mortality appointed by the Council in November at the request of the Committee on Public Health met for the first time on November 29 in the offices of the Society. Dr. Joseph H. Howard was elected permanent chairman by the other members of the committee.

The objectives of the committee were discussed at some length and a number of projects were suggested for further study. Among these were continued and more detailed study of maternal mortality, stimulating hospitals to complete accurate records of maternal morbidity, the study of cesarean sections throughout the state. The committee plans to work closely with the Committee on Public Health and with the State Department of Health. Its members are Joseph H. Howard, Bridgeport, chairman; Eric H. Blank, New London; Carl E. Johnson, New Haven; Norman C. Margolius, Waterbury; Charles H. Peckham, Manchester.

## Dr. Rowley Resigns From Medical Examining Board

Dr. John C. Rowley, who has served as a member of the Connecticut Medical Examining Board continuously since November, 1916, when he replaced Dr. Samuel M. Garlick, has declined reappointment to the Board upon the expiration of his present term on December 31. Dr. Wilmot C. Townsend of Hartford has been appointed by Governor Baldwin for a five-year term beginning January 1, 1947, to fill the vacancy.

Dr. Townsend, who will serve the Board as examiner in medicine, received his B.A. degree from Amherst College and his M.D. from Harvard Medical School in 1925. He interned at the Boston Sanatorium and Hartford Hospital and was assistant in medicine at the Boston City Hospital. He was certified by the National Board of Medical Examiners in 1927 and received his license to practice medicine in Connecticut in July, 1929. Since that time he has been engaged in the practice of internal medicine in Hartford and is an attending physician at the Hartford Hospital.

Dr. Townsend was commissioned as a Major in the Medical Corps, AUS, in September, 1942, and

was promoted to Lieutenant Colonel in April, 1943. He served in this country and abroad, was decorated for meritorious service and received the Bronze Star and was discharged in January, 1946.

## Medical Institutions Approved Under the G.I. Bill of Rights

The following Connecticut institutions and programs have been recommended for approval by the Society and approved by the State Department of Education:

Bristol Hospital, Bristol—X-ray technician.

Charlotte Hungerford Hospital, Torrington—X-ray technician.

Greenwich Hospital, Greenwich—Mixed residency training.

Hartford Hospital, Hartford—Residency in orthopedic surgery.

Hospital of St. Raphael, New Haven—Residency in x-ray.

Lawrence and Memorial Hospital, New London—X-ray technician.

New Britain General Hospital, New Britain—Internships, mixed residencies, residency in pathology.

Stamford Hospital, Stamford—Mixed residency.  
St. Mary's Hospital, Waterbury—Anesthesiology.

## Meetings Held During December

Tuesday, December 3, 4:30 P. M.  
Council of the Society

Monday, December 30, 3:00 P. M.  
Semi-Annual meeting of the House of Delegates, New Haven Medical Association Building, 364 Whitney Avenue, New Haven

## Meetings Scheduled for January

Friday, January 10, 4:00 P. M.  
Council of the Society

Wednesday, January 15  
Council of the New England State Medical Societies, Boston.

Wednesday, January 22, 5:30 P. M.  
Committee on Industrial Health, Dr. C. F. Yeager's residence, 178 Jackman Avenue, Fairfield



Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

- Berneike, Robert R., New Haven (N)
- Keating, John J., New Milford (N)
- Lapenta, Rocco, Hartford (N)
- Lieberthal, Milton D., Bridgeport (A)
- Lubchansky, Jacob H., Uncasville (A)
- Manganiello, Louis O. J., Waterbury (N)
- Pasternak, Maxwell, New Haven (A)
- Perkins, Joseph A., Hartford (A)
- Swirsky, Morgan Y., New Haven (A)

Proposed Health District Bill

Connecticut health officers at their spring meeting on May 29, 1946, in Hartford voted the appointment of a committee to draft a resolution on the need of full time departments of health for cities and towns in Connecticut, and the consideration of financial aid by the state to proposed district departments of health. At the recent official meeting of the health officers of Connecticut, held on November 20, 1946, in Bridgeport, this committee presented the following resolution which was adopted unanimously by all health officers, who filled the meeting room:

WHEREAS, The health officers of the State of Connecticut are cognizant of the limitations of a local department of health under part time health officers such as now exist in most of the towns, boroughs and small cities and

WHEREAS, The House of Delegates of the American Medical Association, on June 10, 1942, passed a resolution urging the establishment of full time modern health services to provide complete coverage of the nation's area and population, and

WHEREAS, The American Public Health Association at its Seventy-first Annual Meeting on October 29, 1942, resolved that all practical measures be taken by the officers and the Executive Board of the American Public Health Association to promote the creation and adequate support of health services by local government throughout the United States to the end that no community of our people shall be left without the public care which can be best supplied only through full time trained medical

officers of health with sufficient numbers of qualified assistant personnel,

BE IT RESOLVED, That the health officers of the State of Connecticut urge the state legislature to take formal action on the Health District Bill which would provide financial assistance to local communities to establish full time districts of health, and

BE IT FURTHER RESOLVED, That copies of this resolution be sent to the Governor and the Legislative Council of the State of Connecticut.

The following committee of health officers representing each county of the state, drafted the resolution:

HEALTH OFFICER	TOWN	COUNTY
D. C. Y. Moore, M.D., Chairman	Bolton	Tolland
H. R. Harris, M.D.	Fairfield	Fairfield
J. N. Gallivan, M.D.	East Hartford	Hartford
W. Bradford Walker, M.D.	Cornwall	Litchfield
N. H. Gardner, M.D.	East Hampton	Middlesex
S. P. Taylor, M.D.	North Haven	New Haven
E. K. Devitt, M.D.	Old Lyme	New London
M. H. Chapnick, M.D.	Putnam	Windham

Howard S. Colwell, M.D., chairman of the public health committee of the Connecticut State Medical Society, served as ex-officio member of this resolution committee.

Death Comes to Stratford Surgeon

Edward H. J. Hennessey, attending surgeon at both St. Vincent and Bridgeport Hospitals and a practitioner in the town of Stratford, died on November 1, 1946, after an illness of three weeks. Dr. Hennessey came to Stratford from Ansonia where he was born. His medical education was obtained at the University of Maryland, Bellevue Hospital, New York City, and St. Francis Hospital, Hartford. One of his first acts on starting practice in Stratford was to join the Volunteer Fire Department in that town. He served as a member of this organization for many years and has been considered the police and fire department surgeon ever since.

Dr. Hennessey was a Captain in World War I, a Fellow of the American College of Surgeons, a member of his local, county and State medical societies, and examining physician for St. James Council, Knights of Columbus, since its organization.

## A.M.A.—HOUSE OF DELEGATES—CHICAGO, DECEMBER 9, 10, 11, 1946

FOR THE first time in its history of almost 100 years the House of Delegates met in semi-annual session last month at the headquarters of the American Medical Association. By a change in the By-Laws effected at San Francisco in July 1946 it will be a regular procedure to hold two sessions annually instead of one as heretofore. Thomas P. Murdock of Meriden served on the reference committee on Legislation and Public Relations and Joseph H. Howard of Bridgeport on the reference committee on Medical Service. Connecticut again was well represented in the activities of the House.

### THE RICH REPORT

Many important reports were submitted for action by the House of Delegates. Among these great interest was shown in the report by The Raymond Rich Associates, public relations experts. Realizing that innovations and changes were necessary in the field of public relations, the Trustees of the A.M.A. early in 1946 engaged this firm to study and recommend necessary changes in this field. Part of the report had been submitted to the House of Delegates by the Board of Trustees at the session in San Francisco. Following this many of the suggested changes were put into effect. In the present session, following the report of the reference committee, the role of the National Physicians Committee provided the greatest discussion. Although the Rich Report did not recommend further support of the National Physicians Committee, it was brought out in the discussion that the public relations experts had failed to secure any evidence to substantiate their statements and that their findings in regard to this Committee lacked sufficient proof to justify them. The House of Delegates voted to request Raymond Rich Associates to continue its study of the National Physicians Committee and to submit a supplementary report before the 1947 annual session of the House of Delegates. Many of the other recommendations of the Rich Report had to do with changes in organization of the American Medical Association and to changes in its health publications, its transcriptions submitted for audition, and its use of radio. A more positive type of public relations pro-

gram was recommended in the Report and approved by the House of Delegates. An executive assistant to the general manager has already been secured to direct this program. The field of radio, according to the reference committee, is so controversial and costly and one in which competition with so many other types of program is so keen that it was recommended and approved by the House of Delegates that this whole program needs further investigation before committing the A.M.A. to excessive expenditures. The complete implementation of the report as submitted by the reference committee on the Rich Report and approved by the House of Delegates will cost an estimated minimum of \$300,000 annually.

### UNITED MINE WORKERS HEALTH FUND

The Council on Medical Service reported on its observations on the developments concerning the United Mine Workers Health Fund and the Welfare and Retirement Fund. A survey has been made by Navy Field Teams under the direction of Rear Admiral Joel T. Boone. This report has not yet been released, however, Admiral Boone addressed the House of Delegates and made certain observations on the present status of medical care in the coal industry. He admitted that "apparent weaknesses in public health programs in the mining regions are deeply disturbing." He found elementary public health control measures lacking in many areas, such as adequate water supply controls, proper disposal of sewage and garbage, reasonable safeguards against contamination from human and animal wastes, protection in food and milk handling, and insect and rodent control measures. Admiral Boone felt that there is a disappointing lack of interest by company physicians and private practitioners in public health work. Physicians have been willing to close their eyes to these needs, rather than attempt to fill the gap between curative and preventive medicine. Prepayment hospital and medical care plans in the coal mining communities will bear close scrutiny. Pre-employment medical examinations often have little value and have been attacked by the unions as being used as a means of exclusion. Because of isolation



and the nature of their work young physicians in these regions have difficulty keeping abreast of advances in scientific medicine.

#### PREPAYMENT MEDICAL CARE PLANS

The rapid growth taking place in the number of prepayment plans was also given prominence by the Council on Medical Service. Already enrollment in many of more than eighty plans in over thirty-three states, Hawaii and Puerto Rico exceeds 50,000 and several plans are approaching the 100,000 mark. The Council foresees a total enrollment of 5,000,000 shortly after the first of the year. The technical problems of plan administration will be handled by Associated Medical Care Plans, an organization of the Plans themselves with headquarters in the Council office. The Seal of Acceptance had been granted twenty-seven medical society approved plans by November 1, 1946.

#### HILL-BURTON LAW PROGRAM

The Council on Medical Service urged that county and State medical societies recognize the importance of the Hill-Burton Hospital Construction law; that the medical profession through its State and county societies should be encouraged to participate actively in plans on programs formulated under the act; that "this participation should include a positive effort to see that local autonomy is maintained; that facilities are placed only where a specific need for them is shown; that any diagnostic clinic facilities be erected only with the approval of the county medical society in whose area they are placed." Special attention was invited to a consideration of the definition of and the principles for operating a health center.

#### GENERAL PRACTITIONERS

A resolution was passed recommending a general practice section in hospitals available to physicians who are not eligible for one of the specialty boards. It was also voted that the Section on General Practice of the A.M.A. study the prerequisites necessary for establishing a General Practice Board and report to the House of Delegates at the next session.

#### APPROVAL OF HOSPITALS

The House of Delegates suggested to the Council on Medical Education and Hospitals and directed it to further the realization of this suggestion, to wit:

The requirements for approval of hospitals shall

be so defined that there shall be (1) adequate protection of the rights of all doctors and their patients in obtaining hospitalization to the end that general practitioners as well as specialists shall have access to and use of hospital facilities; (2) that the criterion of whether a doctor may be a member of a staff or head of a department shall be his actual ability as a doctor and not dependent on special society or board membership; (3) that the American College of Surgeons be urged to conform to these general policies in their procedures in the standardization of hospitals; and (4) that the American College of Physicians be urged to support this policy.

#### POLITICAL ACTIVITY OF U. S. PUBLIC HEALTH SERVICE

The political activities of the U. S. Public Health Service received its share of censure in a resolution introduced into the House of Delegates by the Colorado delegation. The House went on record as condemning without qualification political and partisan activities on the part of officers of the U. S. Public Health Service, including its Surgeon General. It furthermore recommended that steps be taken to prohibit political activity on the part of the U. S. Public Health Service, also to restore the prestige of this important department of our government in the scientific field for which it was created, organized and financed. It was brought out in the discussion that the political and partisan activities above referred to consisted in open support of proposed legislation before the same had been enacted into law, thus constituting political activity of a reproachable nature.

#### VA PERMANENT MEDICAL CORPS MEMBERS

Members of the permanent medical corps of the Veterans Administration are to have a representative in the House of Delegates as soon as the necessary change in the By-laws can be effected. Also members of the VA permanent medical corps are to be admitted as Fellows of the A.M.A. on the same basis as similar members of the Army, Navy and Public Health Service.

#### BILLS SUBMITTED BY ANESTHETISTS

Considerable discussion arose over a resolution submitted by the Section on Anesthesiology to prevent anesthetists other than licensed doctors of medicine from sending statements for services rendered. When such individuals establish their own offices and send out their own statements they are

practicing medicine without being licensed. The discussion brought out the fact that this practice was in no way related to the giving of anesthesia by a nurse under the direction of a physician.

#### NATIONAL HEALTH CONGRESS

On recommendation of the reference committee the House of Delegates voted that a National Health Congress not be established permanently but be called when deemed advisable. The reference committee to which this question was referred considered that such a Congress would duplicate the prerogatives of the House of Delegates. Plans for local health councils are being made, however.

#### SPEAKERS BUREAU

A questionnaire concerning the advisability of having a briefing course at American Medical Association headquarters has been sent to all of the state medical societies. The response has been encouraging. Thirty states have answered the Council's letter. Fourteen already have a speakers' bureau. Twenty-two approve the briefing idea, six are not interested and two said they didn't know.

The purpose of the course will be to provide a select group of doctors with sufficient background, information and material so that they may return to their home state and organize county society Speakers' Bureaus. The letters received indicated an interest in factual data, in a supply of material to be distributed to doctors back home and in competent instruction in the art of public presentation. In order to keep the group small enough to handle, it may be necessary to have two courses: that is, an east and a west group. Two pamphlets and a card system for speakers are to be compiled.

#### QUESTIONNAIRES FROM MEDICAL OFFICERS

The Committee on National Emergency Medical Service reported on its progress to date securing factual data from medical officers in the late war on the better use of medical personnel in the event of another war. Of the pilot questionnaire sent out to 1,000 medical officers, 470 were returned. A revised questionnaire was then drawn up to be sent to 50,000 medical officers. Although all the copies of this second questionnaire have not as yet been sent out, over 18,000 have been returned and over 80 per cent were signed. Many letters accompanied these returned questionnaires. 355 letters have gone to key physicians and 85 replies to these have been received.

#### CENTENNIAL CELEBRATION

Plans for the coming meetings in Atlantic City in June 1947 were reported by the Council on Scientific Assembly and the special Committee on the Centennial Celebration of the American Medical Association. Special features of the Centennial Celebration will be a religious service on Sunday to be addressed by leaders of three different faiths, the appearance of a distinguished guest at each of the three General Scientific Meetings, three panel discussions, an historical seminar of each Section and participation in each Section by a distinguished guest.

#### REPORT OF SECRETARY

George F. Lull, the new secretary of the A.M.A., reported an increase in membership for the past eleven months of 3,674. During the same period the number of Fellows was increased by 3,986. The present membership totals 129,145.

#### MISCELLANEOUS

Dr. Thomas C. Routley, general secretary of the Canadian Medical Association recounted briefly the story of the formation of the World Health Association of which the United States is a member. He pointed out the opportunity medicine is afforded through this organization in furthering world peace plans.

A resolution was passed calling upon the general manager of the A.M.A. to offer his assistance to the President of the United States and to Congress in the selection of the three Surgeons General.

The House of Delegates voted to change the name of the Committee on Postwar Medical Service to the Joint Committee for the Coordination of Medical Activities. The Joint Committee, as was the Committee on Postwar Medical Service, is made up of committees of the A.M.A. and the American College of Surgeons and the American College of Physicians and of individual liaison members representing related organizations and agencies. Problems of post war training of veteran physicians, the development of further residency and postgraduate opportunities, problems of licensure and of medical service in rural communities are part of this committee's program.

The Charter and By-Laws of the American Medical Association are being rewritten and will be presented to the House of Delegates in Atlantic City in June for action.



## SECRETARIES-EDITORS CONFERENCE, CHICAGO, DECEMBER 7 and 8, 1946

THE REAL problems of State medical society secretaries and editors came to the forefront in the discussions carried on at the annual conference held at the A.M.A. headquarters in Chicago last month. Two distinguished guests added color to the occasion, Hon. A. L. Miller, MC, Fourth District, Nebraska, and His Excellency Dwight H. Green, Governor of Illinois. Congressman Miller, a doctor of medicine, addressed the dinner meeting the first evening giving a preview of the 80th Congress and what could be expected of it. Dr. Miller is an optimist, believing there is no occasion to fear a depression such as occurred in 1939. He styles the 80th Congress an American Congress and the recent election an American, not a partisan victory. Enumerating the changes which will occur in the House of Representatives, Dr. Miller called attention to the fact that in only three instances was the P.A.C. successful with all its financial backing from organized labor in defeating members of the previous Congress for re-election. Congressman Miller warned us that Communism has grown up rapidly in this country, and expressed his belief that our government must stop its deficit spending, cut expenses by reducing its bureaus, and then reduce taxes for the individual. He believes the time is here when the public should be considered rather than either labor or capital.

Governor Green called attention to the common ground of public health work where medicine and government meet. Apparently Illinois' chief executive enjoys a similar friendly relationship with the Illinois State Medical Society that Connecticut's governor has enjoyed with our Society for so many years. His manner bespoke his kindly feeling for the medical profession. Calling attention to the recent election, Governor Green emphasized that this was actually a referendum on Federal bureaucratic control vs. private control and the result in his mind had eliminated any possibility of a repetition of an attack by the sponsors of President Truman's health program. Government to be maintained must offer proof in its every department of meeting present needs. The medical profession must push forward its 10 point program of national health needs. Government has a new mandate to give private enterprise all cooperation possible in serving the people.

The part State medical societies are to play in the pre-centennial schedule of national broadcasts was outlined by Dr. W. W. Bauer of the A.M.A. Leading up to the gathering in Atlantic City next June, there are to be 26 weekly broadcasts dramatizing some historical event of importance from 25 different regions of the United States. The Conference was privileged to hear a recording of the first of this series from Alabama, Mississippi and Tennessee, dramatizing the life and accomplishments of James Marion Sims, America's first gynecologist. The broadcast closed with a three minute address by a past president of the Tennessee Medical Association. The 26th in this series of broadcasts will be a special one from Atlantic City.

Our own secretary did a masterful job discussing the State Medical Society and the State Government. Every one who heard him realized he spoke from several years experience with our State officials and our legislature. He characterized the three types of lobbyists, the fixer, the orator and the quiet planner and emphasized the success to be attained by following the methods of the latter.

"The Responsibility of the Individual Physician" was presented by James C. Sargent, M.D., of Milwaukee. Dr. Sargent has found that physicians are becoming more conscious of the need of organization in medicine, but likewise has found an unwillingness on the part of many physicians to function as a foot soldier in the work of organized medicine. He emphasized good leadership, loyalty in the group, and the effectiveness which results only from interest and leg work by the individual physician. He stressed the opportunity physicians have to influence legislators and called attention to two of the problems of the present day, the VA program of medical care and voluntary prepayment plans. Dr. Sargent was a bit disappointing in that he had no solution to offer to the problem of how to interest the indifferent physician in the work of his medical society. Out of the discussion of this paper, however, came the suggestion from Texas that only by getting around the State and coming to know each and every physician could a medical society executive hope to arouse the interest of many. From South Carolina came an even more valuable suggestion that by giving to as many as possible within a

society some task to perform could interest be increased.

The afternoon of the first day was devoted to a further discussion of problems of practical interest. Federal Income and Social Security taxes were covered by Mr. Thomas V. McDavitt of A.M.A. headquarters; the County Medical Society by Mr. M. L. Meadors, director of Public Relations for the South Carolina Association; the Cooperative Medical Advertising Bureau by the chairman of its Advisory Committee; and Public Relations by another expert from headquarters, Mr. Charles Swart. Mr. McDavitt's discussion of taxes was enlightening and probably served to send many a State and county society officer home to settle the status of his society with the Federal government. Mr. Meadors appealed to the county societies as being closest to the public and to the lawmakers and hence best able to cultivate personal contacts. The public has a stake in this \$4,000,000,000 program of medical care now in operation and should receive the benefit of information from the medical profession. He called attention to the existence of one paradoxical situation where many citizens are in favor of socializing medicine while being opposed to socializing business. Laymen are critical of the medical profession and it is the lay secretary who hears these criticisms. With our increased conveniences and income effected through changes in methods of practice the physician in return must interest himself in and contribute to public health programs.

The report of the Cooperative Medical Advertising Bureau was a factual one showing an increase in advertising business carried for the State Journals, bringing the total for 1946 to approximately \$600,000. Mr. Swart, speaking on Public Relations had very little new to offer except to inform us that the general secretary of the A.M.A. is to send out periodic news letters to county and State society officers. This statement of Mr. Swart's is worth noting: "Pamphlets and news releases contribute nothing in public relations until they are read and assimilated." In the discussion of Mr. Swart's presentation our own public relations counsel, Mr. James Burch, outlined to the Conference the manner in which the Connecticut State Medical Society is carrying out its program of public relations.

Following the dinner address by Hon. A. L. Miller the session divided for the evening into a discussion group for secretaries and another for editors. The results of these discussions were presented to the

Conference the following forenoon by their respective chairmen, Douglas L. Cannon, M.D., of Alabama and Robert N. Nye, M.D., of Boston. The secretaries discussed "Commercial Exhibits," better called technical exhibits, and the "Home Office of a State Medical Association." The editors had a somewhat longer, more intensive session, discussing reader interest in and the function of State medical journals. Out of this will probably be developed in the 1947 Conference program a clinic for editors when their own journals will be dissected and criticized by an expert. The managing editor of the District of Columbia *Medical Annals* found by poll greatest interest in the scientific articles and editorials in his journal. State journals of necessity differ and each reflects the ability and characteristics of its editor.

The American Medical Association, as in previous years, was host to the secretaries and editors. At the opening session the chairman of the Board of Trustees, R. L. Sensenich, greeted the representatives from every State in the Union. George F. Lull, secretary and general manager of the A.M.A., was most cordial and to him was due much credit for assisting the program committee in making this Conference of practical value.

## Questionnaire Sent to 45,000 Discharged Medical Officers

A.M.A. COMMITTEE SEEKS OBSERVATIONS AND OPINIONS OF MEDICAL MEN WHO SERVED WITH ARMED FORCES DURING WAR

The Committee on National Emergency Medical Service of the American Medical Association is mailing a comprehensive questionnaire to more than 45,000 discharged medical officers of World War II.

An editorial in the November 23 issue of *The Journal* states that the "questionnaire gives opportunity for an expression by the discharged medical officer of his observations and his opinions. The Bureau of Medical Economic Research of the American Medical Association has aided in the development of the questionnaire, so that the replies can be recorded on punch cards and permit statistical data which should be of vast help to the government services concerned as well as to the physician who volunteers his services in response to the nation's call."

Edward L. Bortz, M.D., of Philadelphia, chairman of the committee, states that the "results of the



questionnaire will serve as a useful guide in preparing for any new national emergency. . . . The committee is a fact finding board and hopes to make recommendations that will lead to better utilization of medical skills and resources in a future emergency."

The editorial states that following "a resolution passed by the House of Delegates of the American Medical Association in December 1945, the Board of Trustees appointed a Committee on National Emergency Medical Service to undertake a critical study of the duties of medical officers during the war, with special reference to (1) opportunities for study, research and actual treatment of the sick, (2) rotation of medical assignments and (3) quasimedical duties for which technicians and specially trained enlisted personnel might replace physicians."

The committee, headed by Dr. Bortz, includes Drs. Harold S. Diehl, Minneapolis; Perrin H. Long, Baltimore; Harold C. Lueth, Omaha; O. O. Miller, Louisville, Ky.; James C. Sargent, Milwaukee, and V. C. Tisdal, Elk City, Okla., thus having in its membership men who served in the Army and Navy medical departments and civilian physicians.

"Several months ago," states the editorial, "the committee sent a pilot questionnaire to 1,000 former medical officers and received 470 replies, which are an indication of the great interest in this study."

### Questionnaire to Provide Information on Medical Care in Rural Areas

A 12-point questionnaire, designed to give a picture of the medical personnel, facilities and health needs of every county in the United States, was mailed in December by the American Medical Association in behalf of the Joint Committee for Coordination of Medical Activities and the Committee on Rural Medical Service. The questionnaires are being sent through the state medical societies to the secretaries of 3,072 county medical societies.

The questionnaire also will provide definite information on the number of physicians in rural areas, the placement of physicians returning from service in the armed forces and the migration of those physicians into farm communities.

"One of the important phases of this questionnaire," says Thomas A. Hendricks, secretary of the Council on Medical Service, "covers the development of prepayment medical care plans in rural areas and the extension of medical care to lower income

groups through health centers and diagnostic clinics."

Virginia Shuler, director of the Bureau of Information, who has been aiding medical officers seeking relocation in areas where medical services are most needed, says that through the "additional comments" on the questionnaire a "wealth of information will be provided which will help the medical profession, in extending better health service in the rural areas."

Attached to each questionnaire, Mrs. Shuler says, is a state highway map for use by the county society in answering the second question.

The following questions are listed:

1. Name of county.
2. Approximate population in the medical service area of which your county is the center. . . . Circle on enclosed map area served by physicians in your county including parts of adjacent counties.
3. Number of physicians servicing this area.
4. How many physicians not previously in this area have come since 1944?
5. Are additional physicians needed in this area? Yes—No. General Practitioners . . . Specialists . . . What Specialists? . . .
6. Number of hospital beds available to the area. . . .
7. Distance of nearest qualified hospitals to center of population of area. . . .
8. Is ambulance service for the transportation of patients from home to hospital readily available? Yes—No. Do you believe it would be desirable? . . . Is ambulance privately, commercially or publicly owned?
9. Is there widespread participation in the Blue Cross or other voluntary hospital insurance plans in your area? . . . If not, do you think the extension of them is desirable?
10. Is there widespread participation in a voluntary medical prepayment plan or plans in your area? . . . If not, do you think the extension of them is desirable? . . . If no medical service plan exists, have you received inquiries concerning the possibilities of the development of a prepaid medical service plan?
11. The Hill-Burton legislation provides for public health centers and diagnostic clinics. Do you have such a center or clinic in your county? . . . If so, is it operated with the approval or direction of the county medical society?
12. Additional comments.

## A.M.A. Plans for Centennial Session at Atlantic City

The American Medical Association will celebrate its centennial in Atlantic City, June 9 to 13, 1947.

Arrangements call for "making it one of the greatest and most interesting medical assemblages ever convened," according to an editorial in *The Journal*.

"Each of the scientific sections of the American Medical Association has been authorized to secure a distinguished speaker from abroad and to include also in its program a review of medical progress in the specialty concerned for the hundred year period," states the editorial. "Each of the general scientific meetings will provide for the presentation of three papers constituting reviews of the advancement in the fields discussed, followed by panel discussions on such subjects as the modern management of heart disease, emergency surgery and antibiotics in therapy."

Another highlight of the centennial session is "the utilization of Sunday, June 8, as a special public health day. A religious program is being arranged with representatives of the leading faiths of our country. This will be held in the great auditorium in convention hall and will no doubt be broadcast on one of the national chains. At the same time congregations assembled for religious services elsewhere throughout the nation will be given messages regarding the advancement of medical science and the improvement in the public health that have occurred during the hundred year period.

"The division of motion pictures in the headquarters office of the American Medical Association is at present engaged in the development of two motion pictures dealing with the lives of the distinguished American physicians of the period concerned and with the evolution of motion pictures in medical teaching. The first public showings are contemplated for Monday evening, June 9. . . ."

The President's Reception will be among some of the many other features planned for the centennial celebration. *The Journal* editorial states that "distinguished foreign guests, as well as the officers of the American Medical Association, will on that occasion be honored at the reception, and music will be provided by one of the leading orchestras of the nation."

Dr. Morris Fishbein, editor of *The Journal*, is writing a history of the American Medical Associa-

tion which is appearing serially in *The Journal*. The complete work will be published in book form and will be available for the centennial celebration.

## Rural Health Conference to be Held in Chicago, February 7, 8

The American Medical Association through its Committee on Rural Medical Service, in cooperation with nationally organized farm groups, is arranging a Second Annual Conference on Rural Health Service to be held at the Palmer House in Chicago Friday and Saturday, February 7 and 8, 1947.

F. S. Crockett, M.D., chairman of the committee, states that "it is the hope that this meeting will give the farmer and the doctor an opportunity to exchange views regarding many questions which are of vital importance in developing a better health service in rural communities throughout the United States."

Invitations have been sent to over 1,300 representatives of farm organizations and leaders in health education which include the superintendents of education in the various states, representatives of state health departments and the deans of medical colleges.

The Friday morning session will begin with registration at 9:00 A. M., following which Dr. Crockett will discuss the purpose of the conference. George F. Lull, M.D., secretary and general manager of the American Medical Association, will welcome the attending groups and then Albert S. Goss, master of The National Grange, Washington, D. C., will lead a discussion on "The Farmer and the Medical Service Program."

The morning session will include two more discussion groups. One will concern itself with the "Methods of Bringing and Holding Doctors in Rural Areas," with Fred A. Humphrey, M.D., chairman of the Colorado Committee on Rural Medical Service, Fort Collins, and H. E. Slusher, president of the Missouri Farm Bureau Federation, Jefferson City, as speakers.

The second group, which will concern itself with "Hospital Facilities and Health Centers, for Rural Areas," includes: Mrs. Roy C. Weagly, president of The Associated Women of the American Farm Bureau Federation, Hagerstown, Md.; Graham L. Davis, director of the Division of Hospitals, W. K. Kellogg Foundation, Battle Creek, Michigan, and



member of the Advisory Board of the Federal Hospital Council; Joseph W. Fichter, master of the Ohio State Grange, Columbus; Robin C. Buerki, M.D., dean of the Graduate School of Medicine, University of Pennsylvania, Philadelphia, and member of the Advisory Board of the Federal Hospital Council.

There will be a discussion on the "Voluntary Medical Prepayment Plans as They Apply to Rural Communities" by Mrs. Gladys T. Edwards, director of Education of the Farmers Educational and Co-operative Union of America, Denver, Colo.; James R. McVay, M.D., vice-chairman of the Council on Medical Service, American Medical Association, Kansas City, Mo., and J. S. Jones, secretary of the Minnesota Farm Bureau Federation, St. Paul.

Friday afternoon will be devoted to round table discussions at A.M.A. headquarters, 535 N. Dearborn, Chicago. The topics are:

"Hospital Facilities and Health Centers"—Allen T. Stewart, M.D., chairman; Mrs. Roy C. Weagly, co-chairman.

"Methods of Bringing and Holding Physicians and Dentists in Rural Areas"—J. S. Jones, chairman; H. B. Mulholland, M.D., co-chairman.

"Voluntary Medical Prepayment Plans"—James F. Doughty, M.D., chairman; Mrs. Paul Palmer, co-chairman.

"Nursing Needs of Rural Communities"—Mrs. Charles W. Sewell, chairman; Charles W. Holman, co-chairman.

"Health Council as Agency for Promoting Rural Health"—J. Paul Jones, M.D., chairman; Joseph W. Fichter, co-chairman.

"Medical Care for Lower Income Groups"—Ransom E. Aldrich, chairman; Mrs. Gladys T. Edwards, co-chairman.

At the conference Saturday morning to be held at the Palmer House, there will be a presentation of the recommendations of the round table committees and general discussions. The two-day meeting will close with a luncheon at which the guest speakers will be: J. Melville Broughton, of Raleigh, N. C.; Harrison Shoulers, M.D., Nashville, Tenn., president, A.M.A.; and Olin West, M.D., Nashville, Tenn., president-elect, A.M.A.

### Dean Blake Accepts Lasker Group Award for Army Epidemiological Board

The Army Epidemiological Board was named one of five groups in the fields of medical research and

public health administration to receive the coveted Lasker Group Award. Francis G. Blake, dean of the Yale University Medical School, chairman of the board during the time for which it was cited, accepted the award, a silver statuette, on behalf of the board.

The Army Epidemiological Board, originally called the "Board for the Investigation and Control of Influenza and Other Epidemic Diseases in the Army," was established by order of the Secretary of War on January 11, 1941, on recommendation of The Surgeon General, U. S. Army, dated December 27, 1940. The Surgeon General's recommendation was based upon the memorandum and recommendation of the same date prepared by Brigadier General James S. Simmons, MC—USA, who was then a Lieutenant Colonel, and was developing the Preventive Medicine Service in the Office of The Surgeon General.

Francis G. Blake, M.D., Sterling Professor of Medicine, and Dean, Yale University School of Medicine, was appointed Consultant to the Secretary of War and President of the Army Epidemiological Board in January 1941, and served continuously as President of this Board throughout the war and until June 30, 1946. In addition to his great service as President, he rendered distinguished service in the field, during the period October to December 1943, as Director of a special commission sent to New Guinea by the Office of the Surgeon General and the United States of America Typhus Commission, to investigate scrub typhus fever (tsutsugamushi disease).

In 1941, the Board was promptly organized into commissions, which carried through the war. The names of the Commissions indicate the fields of work:

1. Commission on Acute Respiratory Diseases.
2. Commission on Air-Borne Infections.
3. Commission on Epidemiological Survey
4. Commission on Hemolytic Streptococcal Infections.
4. Commission on Influenza.
6. Commission on Measles and Mumps.
7. Commission on Meningococcal Meningitis.
8. Commission on Neurotropic Virus Diseases.
9. Commission on Pneumonia.
10. Commission on Tropical Diseases.

The membership of the Central Board and Commissions included 125 of the leading American

authorities in the fields of investigation and control of infectious diseases. Each man in this group held appointment as a Consultant to the Secretary of War. Their services were available at all times to The Surgeon General of the Army.

The Commissions, operating under War Department research contracts, carried on their fundamental and practical investigations in the laboratories of most of the chief universities and scientific institutes of the United States. In addition, members of the Commissions made field studies in posts and camps in the United States and on extensive missions to all theaters of operations overseas. The following are some of the most notable achievements of the Board and Commissions:

- a. Developing, testing and application of an inactivated virus vaccine against influenza.
- b. Development and application of a vaccine against Japanese B encephalitis.
- c. Basic studies and tests proving the efficacy of sulfadiazine prophylaxis against meningococcal meningitis.
- d. Demonstration of the virus nature of the agent of infectious hepatitis, with indications as to its mode of spread and ultimate possibility for control.
- e. Proof of the virus nature of the agent of atypical pneumonia.
- f. Extensive investigations of acute respiratory diseases and their control in Army camps.
- g. Basic studies and development of methods of immunization against measles and mumps.
- h. Fundamental advances in knowledge of the use of triethylene glycol vapors and aerosols for the purification of air and improvement in the use of these materials for the control of acute respiratory diseases.
- i. Fundamental and practical investigations on the epidemiology and spread of coccidioidomycosis, with development of method of control in certain dusty areas.
- j. Investigations on schistosomiasis in the Philippine Islands and Japan.
- k. Investigations on the characteristics and control of dysenteries and diarrheal diseases.

Thus far about 300 papers reporting the results of the work of the Commissions have been published in scientific journals. All the knowledge acquired from this extensive Army medical research has been made available as rapidly as possible to civilians. The

Board's contributions have been made both to military preventive medicine and to civilian public health.

### Social Workers Meet in Bridgeport

That the psychological relationship between physician and patient may in itself contain curative qualities; that delinquency may result from ignoring possible sight or hearing difficulties among "backward" school children; and that the health of the indigent aged can be best preserved by providing them with "homes" rather than institutions, were among leading health questions discussed at the 36th Annual Conference of Social Work held in Bridgeport November 14 and 15.

Attended by more than 1,000 doctors, nurses, social and health organization workers, the two-day conference was the largest of its kind ever held in Connecticut. Featured by 26 discussion panels, four of which were devoted to medical subjects, its activities were too numerous to be held in any single building. To attend the various sessions, participants were in constant movement from the conference headquarters at the Hotel Stratfield to the American Legion Hall, the County Court House, Locke Hall, the Y. W. C. A., the Salvation Army Building, and the Community Advisory Service Center, all within several blocks of the hotel.

One of the most active discussion groups was that on "Social and Emotional Aspects of Illness," led by Frederick C. Redlich, M.D., assistant professor of psychiatry, Yale University School of Medicine, who explained that the relationship between a doctor and his patient often produced a psychological effect of benefit to the patient.

"It is of the utmost importance," he said "to understand this, because there is often something in the relationship which may be helping the patient."

A capacity audience of more than 125 persons attended the panel on "Care of the Aged," during which A. Nowell Creadick, M.D., spoke on the problems of the aged in Connecticut. Chairman of the Commission to Study the Needs of the Chronically Ill and Aged, the speaker told his audience that, in his opinion, indigents in this group could be better provided for through state subsidy of existing private institutions than by large scale construction of state buildings for this purpose. It was pointed out that Connecticut now spends \$8,000,000 annually to care for its aged and chronically ill.



Edward H. Truex, Jr., M.D., of Hartford, spoke on "Rehabilitation of the Aurally Handicapped" during a panel discussion on "The Chronically Ill," of which Dr. Franz Goldman, clinical professor of public health, Yale University School of Medicine, was chairman. A. Bliss Dayton, M.D., of New Haven, was discussion leader during the afternoon session of this panel, and a paper on "The Newer Therapy for Epileptics" was presented by Margaret A. Lennox, M.D., assistant professor of neurology, Yale University School of Medicine.

### Connecticut Cancer Society News

E. Cotton Rawls, M.D., has been appointed president of the Stamford Branch, Connecticut Cancer Society.

At its regular monthly meeting, the State Executive Committee was advised that a new plan has been arranged whereby three doctors from each Tumor Clinic in the state will visit other Tumor Clinics four times during the year to exchange ideas and information. They will receive a fee for their time plus traveling expenses, the money to be supplied by the State Department of Health from federal funds. The plan was formed by the State Department of Health and the Association of Tumor Clinics with a representative from the Connecticut Cancer Society. The State Department of Health is planning schedules and trying to interest general practitioners.

One study of the statistics recorded by the Division of Cancer Research indicates how much can be gained by the increased use of the 40,000 cases recorded there. Recently Dr. E. J. Ottenheimer delivered a paper before the New England Surgical Association, Worcester, Massachusetts, on 1,600 consecutive cases of cancer of the rectum in large and small hospitals of Connecticut. The American Cancer Society is eager to see Connecticut's statistics studied and made generally available to help cancer program planning.

The Tumor Clinic of the New Haven unit of Grace-New Haven Community Hospital is open to residents of the New Haven District by referral from physicians, social agencies, or the New Haven office of the Connecticut Cancer Society. Persons who wish consultation or examination may apply there. The service is open to private patients as well as those who are unable to pay. For the time being, this service will be restricted to the New Haven area.

### Grants-in-aid for Cancer Research

Grants-in-aid amounting to approximately \$200,000 have been recommended by the National Advisory Cancer Council for the support of cancer research projects in 21 universities, hospitals, and research institutions, the U. S. Public Health Service has announced.

The variety of projects covered by the grants illustrate the complexity of the cancer problem and the many angles from which research must be carried on to solve it. The projects include:

YALE UNIVERSITY, NEW HAVEN, CONNECTICUT

Steroids and enzymes in cancer under the direction of Dr. William T. Salter. Grant: \$7,500.

HARVARD UNIVERSITY, BOSTON, MASSACHUSETTS

Investigation of pathologic aspects of gastric cancer and related lesions under the direction of Dr. Shields Warren. Grant: \$9,684.

The grants were recommended at the Council's thirty-second meeting which was held November 8 at the National Cancer Institute, Bethesda, Md., and presided over by Dr. James A. Crabtree, Acting Surgeon General of the U. S. Public Health Service. The agenda of this meeting also included a report from the committee on cancer in the medical school curriculum and the committee on gastric cancer.

### Cancer in Medical School Curriculum

A special committee composed of representatives of 14 medical schools and of the National Research Council met recently with the National Advisory Cancer Council to discuss the place of cancer in the medical school curriculum. A U. S. Public Health Service announcement said that the meeting, which was held at the National Cancer Institute, Bethesda, Md., marked an advance in efforts to eliminate the lag between what is known about cancer and the application of this knowledge in medical practice.

Frank E. Adair, M.D., chairman of the committee, declared it is obvious that something must be done to improve the education of medical students in cancer which ranks second as a cause of death in the United States. The teaching of medicine has become more and more difficult due to the vastness and intricacy of the field, and many educators recognize the need for changes in the curriculum.

Among the suggestions made for improving the

medical curriculum were the establishment of professorships in clinical cancer, greater use of the facilities of cancer diagnostic and treatment clinics and cancer prevention clinics, the establishment of cancer institutes or hospitals in connection with medical schools in large urban centers, and greater emphasis in the medical school on the importance of preventive medicine.

A committee to outline a plan of teaching and to make recommendations which will be sent to all medical schools will be appointed later.

Dr. Adair, who heads the present committee, is a member of the National Advisory Cancer Council, president of the American Cancer Society and professor of surgery, Cornell University Medical College. On this committee from Connecticut are Milton C. Winternitz, professor of pathology, Yale University School of Medicine, and George M. Smith, executive director, National Advisory Cancer Council, Yale University School of Medicine.

### Dr. Winternitz Addresses New Haven Cancer Committee

Dr. Milton Winternitz, professor of pathology at the Yale University School of Medicine, addressed more than 100 persons at a meeting of the New Haven Cancer Committee Friday evening, November 22, at the New Haven Medical Association building.

Speaking on the subject "What We Know About Cancer," Dr. Winternitz traced the history of cancer research and told his audience that the cause of the disease may be discovered by scientists now probing in the sub-microscopic world of atomic structures.

A new motion picture on cancer, "Time is Life," was shown by a representative of the Connecticut Cancer Society following the talk. Other brief talks were given by Mrs. George Cowgill, chairman of the service committee; Miss Elizabeth Fox, director of the Visiting Nurses' Association; and Miss Dorothy Schober, health education consultant, Council of Social Agencies. A social hour followed the program.

### Hartford High School Juniors 99% Tuberculin Tested

Ninety-nine per cent of all juniors attending Hartford, Connecticut, high schools participated

this year in the voluntary tuberculin testing program carried on by the Hartford Tuberculosis and Public Health Society in cooperation with the Board of Education and the Health Department. According to *Let's Look At It*, publication of the association, this excellent record is due to the combined efforts of the principals, nurses, teachers, Junior Board and Dr. Hennessy, chairman of the association's medical advisory committee.

Tuberculin testing is offered each year by the association. Two tests are given, with the second one limited to those students whose first test was negative. A careful check is made after each test and those students showing a positive reaction are x-rayed by the Hartford Health Department.

### New Tuberculosis Association Organized in New Haven

A new association incorporated as the New Haven Tuberculosis and Health Association was organized on October 21, 1946, for the purpose of conducting a broad and expanded program of tuberculosis education, case-finding and rehabilitation in New Haven. Following a survey made by the National Tuberculosis Association, the recommendations were discussed at a conference some months ago with representatives of the Employees Tuberculosis Relief Association, and the State and National Associations. As a result of this conference the Employees Tuberculosis Relief Association decided to restrict its activities to its primary purpose of relief for industrial workers and their families, therefore a new group should be organized to develop the broader program as outlined in the authorized forms of tuberculosis work to be financed by the sale of Christmas Seals.

Professor Ira V. Hiscock acted as temporary chairman of the organizing group, with Miss Helen M. Currier as temporary secretary, and a constitution was adopted naming the following objectives for the Association: To conduct an educational campaign against tuberculosis and for the promotion of health; to develop effective health education methods; to ascertain unfulfilled health needs; and to cooperate with official and other health agencies.

Officers and directors elected to serve until the first annual meeting include: Dr. David R. Lyman, president; H. Gordon Sweet, vice-president; Mrs. Stuart H. Clement, secretary; and W. Herbert Frost, treasurer. In addition to these officers the following



comprise the executive committee: Prof. Ira V. Hiscock; Dr. Joseph N. D'Esopo; and Miss Gertrude Touchton. Other directors include: Dr. Creighton Barker, D. Spencer Berger, Rev. William J. Daly, Mrs. Theodore S. Evans, Mrs. James Ross Gillie, Patrick J. Goode, Mrs. Edward H. Goin, Mrs. Clarence A. Hadden, Mrs. Frederick W. Hilles, Mrs. Samuel C. Harvey, Richard C. Lee, Dr. Joseph I. Linde, Raymond A. Loring, Miss Elsa Montgomery, Justin L. O'Brien, Dr. Arnold B. Rilance, Gino Santella, Rev. Philip G. Scott, Maurice B. Ullman, and Dr. C.-E. A. Winslow.

H. Gordon Sweet was named to serve as the representative director on the board of the Connecticut Tuberculosis Association for two years, and William T. Beazley was appointed chairman of the 1946 Christmas Seal Sale. The Association has taken offices at 341 State Street, and Miss Virginia Cook, a graduate of Syracuse University with postgraduate work at New York Hospital, Cornell Medical Center, has been loaned to the New Haven Association as a field secretary from the Connecticut Tuberculosis Association.

### Sister Kenny

Two county medical society publications in New York State have taken up the cudgel against the "Sister Kenny" film now being shown on the screen. The closing paragraph of an editorial in *New York Medicine* perhaps sums up the fairest attitude to take in this controversy. We quote:

"Nurse Kenny has made an important contribution. She might make a far greater contribution if she would acknowledge her human fallibility and recognize the paramount reality—that in adopting and modifying her method without necessarily accepting her theory, the medical profession has only conferred upon her the same treatment that is the lot of other great but fallible figures in medical history from the days of Aesculapius even to the present day.

### Dr. Foote Goes to Society for Prevention of Blindness

The appointment of Franklin M. Foote, M.D., as medical director of the National Society for the Prevention of Blindness has been announced by Mrs. Eleanor Brown Merrill, executive director of the

Society. Dr. Foote was formerly district health officer of the Kips Bay-Yorkville Health District of the New York City Health Department. Prior to that, he was chief of the Division of Local Health Administration, Connecticut State Department of Health. Dr. Foote is assistant professor of Public Health and Preventive Medicine at Cornell University Medical College.

A native of Great Barrington, Mass., Dr. Foote holds degrees of B.S., M.D., and DR.P.H. from Yale University. During World War II, he served as a Major in the Medical Corps of the United States Army, and was awarded the Army Commendation Ribbon for teaching of preventive medicine at the Medical Field Service School, Carlisle Barracks, Pa., and at the Brook Army Medical Center, Fort Sam Houston, Tex. Dr. Foote is a member of the American Medical Association, a fellow of the American Public Health Association, a member of the Harvey Society of New York City and of the New York County and New York State Medical Societies.

### Blue Cross Has New Publicity Manager

On November 7, 1946, the appointment was announced of George P. Chapman, well known New Haven resident, to the post of publicity manager in the Publicity Relations Department of Connecticut Blue Cross.

Mr. Chapman has long been associated in the publishing and public relations field and has a wide acquaintance throughout the state in newspaper and radio circles. For five years he was editor of *Winchester Life*, the employee's monthly magazine of the Winchester Repeating Arms Company, division of Olin Industries, Incorporated. Under Chapman's editorship the Winchester publication attained many high honors and became one of the most outstanding periodicals in the field of industrial publications.

As president of the New Haven Public Relations and Industrial Editor's Association Mr. Chapman has served for many years on the publicity committees for such community programs as the Red Cross, Fire Prevention, Infantile Paralysis, Community Chest and many others.

Mr. Chapman's duties with the rapidly growing Connecticut Blue Cross will consist of informing the public and the more than a half million members of the non profit hospital plan on the progress of the program in the various communities in the state.

## Doctor---

### INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS BELIEVE . . .

"A program for national health should include the administration of MEDICAL CARE TO ALL VETERANS, with payment by the Veterans Administration, through a plan mutually agreed upon between the state medical association and the Veterans Administration."\*

Physicians are doing their part to provide veterans with good medical care supplementary to the services of tuberculosis sanitoriums and mental hospitals. In Connecticut, as in other states, plans have been mutually agreed upon by the doctors and the Veterans Administration.

Connecticut physicians are cooperating fully with the Veterans Administration to care for the veteran *in his own home and in his own community by the doctor and in the hospital of his own choice.*

We believe such cooperative efforts are necessary. Medical care for veterans was not good after World War I. *We are determined that it be good this time.*

WE CONNECTICUT PHYSICIANS BELIEVE THAT THE BEST MEDICAL CARE, INCLUDING HOSPITALIZATION, SHOULD BE PROVIDED FOR VETERANS THROUGH THE COOPERATIVE ACTION OF THE VETERANS ADMINISTRATION AND THE MEDICAL PROFESSION.

### COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the  
Council on Medical Service of the American Medical Association

<sup>1</sup>High Standard of Living

<sup>3</sup>Adequate Maternity Care

<sup>5</sup>Research In The Medical Sciences

<sup>2</sup>Preventive Medical Services

<sup>4</sup>Adequate Infant and Child Care

<sup>6</sup>Widespread Health Education

<sup>7</sup>Extension of Voluntary Prepaid Medical and Hospital Care Plans

<sup>8</sup>Health and Diagnostic Centers and Hospitals

\*Adequate Medical and Hospital Care For The Veteran

Proper Development of National Philanthropic Health Agencies

See Connecticut State Medical Journal, <sup>1</sup>May, page 434; <sup>2</sup>June, page 497; <sup>3</sup>July, page 591;

<sup>4</sup>August, page 677; <sup>5</sup>September, page 781; <sup>6</sup>October, page 863; <sup>7</sup>November, page 937;

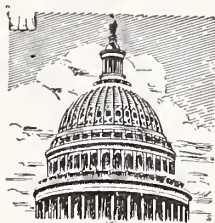
<sup>8</sup>December, page 1026.

**If Free Enterprise in American Medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients. Next month's Journal will deal with "Development of National Philanthropic Health Agencies" in our "Common-Sense Health Program."**



## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*Fairfield County*, Charles H. Sprague, Bridgeport  
*Hartford County*, Benjamin B. Robbins, Bristol  
*Litchfield County*, W. Bradford Walker, Cornwall  
*Middlesex County*, Frank H. Couch, Cromwell  
*New London County*, Edmund L. Douglass, *Chairman*  
 Groton  
*New Haven County*, Charles T. Flynn, New Haven  
*Tolland County*, John E. Flaherty, Rockville  
*Windham County*, Brae Rafferty, Willimantic

PUBLIC  
AFFAIRS

## United States Senators

Raymond E. Baldwin, Stratford

Brien McMahon, South Norwalk

## Congressman-at-Large

Antoni N. Sadlak, Rockville

## Congressmen by Districts

1st District, William J. Miller, Wethersfield  
 2nd District, Horace Seeley-Brown, Pomfret Center  
 5th District, James T. Patterson, Naugatuck

3rd District, Ellsworth B. Foote, North Branford  
 4th District, John Davis Lodge, Westport

## 1947 CONNECTICUT GENERAL ASSEMBLY

Governor, James L. McConaughy, Cornwall  
 Lieutenant-Governor, James C. Shannon, Bridgeport  
 Secretary of State, Frances Burke Redick, Newington

Treasurer, Joseph A. Adorno, Middletown  
 Comptroller, Fred R. Zeller, Stonington  
 Attorney-General, William L. Hadden, West Haven

## State Senate

## District

1—Patrick J. Ward (d)  
 2—Alfred F. Wechsler (d)  
 3—Rocco D. Pallotti (d)  
 4—Charles S. House (r)  
 5—Robert E. Parsons (r)  
 6—Andrew J. Kata (r)  
 7—Ernest E. Carpenter (r)  
 8—Elmer E. Nordstrom (r)  
 9—Harold E. Alprovis (r)  
 10—William F. Lynch (d)  
 11—B. Fred Damiani (d)  
 12—Herbert S. MacDonald (r)

## District

13—Carter H. White (r)  
 14—Luke H. Stapleton (r)  
 15—Francis J. Summa (r)  
 16—Martin F. Sullivan (d)  
 17—William Ablondi (r)  
 18—Robert P. Anderson (r)  
 19—Dominic Pedace (r)  
 20—Harold F. Brown (r)  
 21—Nicholas J. Palladino (r)  
 22—Albert L. Coles (d)  
 23—Cornelius Mulvihill, Jr. (d)  
 24—Alice Rowland (r)

## District

25—William E. Sheehy, Jr. (r)  
 26—Stanley Stroffolino (r)  
 27—Vincent Giampietro (r)  
 28—Jean M. Bachand (r)  
 29—Lionel E. Raymond (r)  
 30—S. L. Blakeslee (r)  
 31—John P. Whitehead (r)  
 32—Walfred C. Carlson (r)  
 33—John J. Monnes (d)  
 34—William R. Peterson (r)  
 35—Howard A. Pratt (r)  
 36—George Griswold (r)

Republicans, 27; Democrats, 9; Total, 36

## State Representatives

## HARTFORD COUNTY

Avon, John D. Alsop (r)  
 Berlin, James B. Ellsworth (r); Stephanie R. Kamenski (r)  
 Bloomfield, Harold J. Watkins (r)  
 Bristol, James P. Casey (d); Leslie S. Manchester (d)  
 Burlington, James B. Mullen (r)

Canton, Edward J. Bokorney (d)  
 East Granby, Beula P. Granger (r)  
 East Hartford, Howard B. Noble (r); Howard E. Bidwell (r)  
 East Windsor, George W. Christoph (r); Albert G. Goettler (r)  
 Enfield, Lawrence D. Griffin (d); Stanley Yesukiewicz (d)

Farmington, Louis Shapiro (r); Edward C. Swan (r)  
 Glastonbury, N. Glenn Richards (r); Olive B. Tyrol (r)  
 Granby, Bertha W. Colton (r); Philip E. Devnew (r)  
 Hartford, John P. Cotter (d); Charles C. Merlet (d)

Hartland, Perry M. Ransom (r);  
 Dwight G. Stone (r)  
 Manchester, Julia P. Crawford (r);  
 Sherwood G. Bowers (r)  
 Marlborough, Roy F. Fuller (r)  
 New Britain, Paul J. Cassarino (r);  
 Leone H. Miller (r)  
 Newington, E. Welles Eddy (r); Helen  
 L. Warner (r)  
 Plainville, Charles Hadfield (r); John E.  
 Lamb (r)  
 Rocky Hill, Lillian L. Yerrington (r)  
 Simsbury, George H. Perry, Sr. (r);  
 Robert W. Tuller (r)  
 Southington, Mary E. Flynn (d); John  
 J. Moran (d)  
 South Windsor, Harry F. Farnham (r)  
 Suffield, Arthur G. Bissell (r); Edward  
 M. White (r)  
 West Hartford, William H. Dallas (r);  
 Kenneth Hoffman (r)  
 Wethersfield, Thomas A. Drennan (r);  
 Burton A. Harris (r)  
 Windsor, Carlan H. Goslee (r); Hazel  
 Thrall Sullivan (d)  
 Windsor Locks, Edward J. Lally (d)  
 38 Republicans, 11 Democrats

## NEW HAVEN COUNTY

Ansonia, Gregory H. Comcowich (r);  
 Frederick B. Richter (r)  
 Beacon Falls, Clara O'Shea (d)  
 Bethany, Stanley H. Downs (r)  
 Branford, Raymond F. Barnes (r);  
 Frank Kaminsky (r)  
 Cheshire, Harry F. Jewett (r); Robert  
 W. Fox (r)  
 Derby, Frank Pepe (d); Thomas Kiley  
 (d)  
 East Haven, William Jaspers (r); Char-  
 lotte E. Miller (r)  
 Guilford, Winfred P. Chittenden (r);  
 George C. Conway (r)  
 Hamden, Edward H. Kummer (r);  
 John R. Thim (r)  
 Madison, Frederick H. Holbrook (r)  
 Meriden, Benjamin J. Kopacz (r); Al-  
 fred R. Tomassetti (r)  
 Middlebury, Harold F. Braman (r)  
 Milford, Noyes L. Hall (r); Helen M.  
 Smith (r)  
 Naugatuck, Joseph V. Rosko (d);  
 Daniel J. Walsh (d)  
 New Haven, Elizabeth B. Gillie (r);  
 Irving Horowitz (r)  
 North Branford, Mary H. McDonnell  
 (r)  
 North Haven, Albert W. Cretella (r);  
 Kingsley T. Leighton (r)  
 Orange, Marshall J. Baldwin (r); Joseph  
 P. Gregory (r)

Oxford, R. Harold Treat (r)  
 Prospect, George H. Cowdell (r)  
 Seymour, John M. Karlak (r); Bernard  
 H. Matthies (r)  
 Southbury, Robert C. Mitchell (r)  
 Wallingford, Samuel B. MacDonald (r);  
 Frederick J. Maddocks (r)  
 Waterbury, Ruth A. Jones (r); Wil-  
 liam Powell (r)  
 West Haven, See Town of Orange  
 Wolcott, Rose E. Wakelee (r)  
 Woodbridge, Chester C. Hitchcock (r)  
 37 Republicans, 5 Democrats

## NEW LONDON COUNTY

Bozrah, Laurence M. Gilman (r)  
 Colchester, Rubin Cohen (d); Arthur  
 Solomon (r)  
 East Lyme, Fred A. Beckwith (r)  
 Franklin, Arnold P. Manning (r)  
 Griswold, Edmond J. LaCroix, Jr., (d);  
 Robert J. McKenna, Jr., (d)  
 Groton, George L. Farnham (r);  
 Thomas L. Haggerty (r)  
 Lebanon, James S. Kahn (r); David  
 Walsh (r)  
 Ledyard, Edmond H. Lamb (r)  
 Lisbon, Ralph H. Fitch (d)  
 Lyme, Ray L. Harding (d); Charles W.  
 Jewett (r)  
 Montville, Aime Bergeron (d)  
 New London, John M. Kamercia (r);  
 Hubert W. Ryan (r)  
 North Stonington, William F. Morgan  
 (r); David L. Stillman (r)  
 Norwich, Rene L. Dugas (r); William  
 Gromko (r)  
 Old Lyme, E. Lea Marsh, Jr. (r)  
 Preston, Georgana C. Miller (r); Wil-  
 liam N. Wheeler (r)  
 Salem, Joseph Swider (d)  
 Sprague, Charles L. Papineau (d)  
 Stonington, Francis J. Connors (r);  
 Samuel Counsell (r)  
 Voluntown, James E. Fuller (d)  
 Waterford, Arthur Barrows (r); James  
 G. Hammond (r)  
 23 Republicans, 9 Democrats

## LITCHFIELD COUNTY

Barkhamsted, Prosper F. Lavieri (r);  
 Rosabelle Rowley (r)  
 Bethlehem, J. L. Schwabacher (r)  
 Bridgewater, William M. Curtis (r)  
 Canaan, William F. Landon (r)  
 Colebrook, Erving Pruyn (r); Wyllys  
 P. Smith (r)  
 Cornwall, Fred J. Bate (d); John F.  
 Schereschewsky (r)

Goshen, John A. Minetto (r); Clarence  
 A. Vaill (r)  
 Harwinton, Henry J. Delay (r); Chaun-  
 cey E. Hutchings (r)  
 Kent, Thomas Johnston Boyd (r)  
 Litchfield, Isabel C. Rylander (r); Karl  
 Webster (r)  
 Morris, William C. Weik (r)  
 New Hartford, Signa C. Dickinson (r);  
 Harris R. Hunt (r)  
 New Milford, Edward A. Ambler (r);  
 Benjamin L. Barringer (r)  
 Norfolk, Philip E. Curtiss (r); Olive E.  
 Schmeltz (r)  
 North Canaan, Edwin B. Stone (d)  
 Plymouth, Harry C. Clow (r); Lester J.  
 Pratt (r)  
 Roxbury, John F. Pickett (r)  
 Salisbury, William B. Barnett (r); Wil-  
 liam G. Raynsford (r)  
 Sharon, Clarence H. Eggleston (r);  
 William R. Riley, Jr. (r)  
 Thomaston, Luke F. Martin (d)  
 Torrington, Patsy R. Mastrascia (d);  
 James Quinn (r)  
 Warren, Earle Smith (r)  
 Washington, Robert J. Benham (r);  
 William S. Ford (r)  
 Watertown, Eugene H. Lamphier (r);  
 Arthur H. Russell (r)  
 Winchester, Walter V. Davey (r);  
 James L. Glynn (r)  
 Woodbury, Clifford F. Martin (r);  
 Arthur E. B. Tanner (r)  
 39 Republicans, 4 Democrats

## MIDDLESEX COUNTY

Chester, Charles McKew Parr (r)  
 Clinton, John L. Eliot, Sr. (r)  
 Cromwell, Hjalmar N. Johnson (r)  
 Durham, Mary R. Arrigoni (r); Rich-  
 ard C. Parmelee (r)  
 East Haddam, William Berner (r); Wil-  
 liam E. Nichols (r)  
 East Hampton, Howard J. Engel (r);  
 Reuben E. Ostergren (r)  
 Essex, Thomas H. MacWhinney (r)  
 Haddam, Albert H. Hubbard (r);  
 Charles S. Ingham (r)  
 Killingworth, Edith H. Downing (r);  
 A. Leslie Perkins (r)  
 Middlefield, Charles E. Lyman, Jr. (r)  
 Middletown, Alexander W. Dzialo (d);  
 Michael Tommasi, Jr. (d)  
 Old Saybrook, George A. Maynard (r)  
 Portland, William P. Spear (r)  
 Saybrook, Ossian E. Ray (r); Joseph  
 Waz (r)  
 Westbrook, John M. Spencer (r)  
 20 Republicans, 2 Democrats



FAIRFIELD COUNTY  
Bethel, Herbert B. Wanderer (r)  
Eridgeport, Joseph C. Bober (r); Milton J. Herman (d)  
Brookfield, Curtis H. Dickens (r)  
Danbury, Walter Scott (r); Arthur R. Tartaglia (r)  
Darien, Edward H. Delafield (r); Thomas O'Connor (r)  
Easton, Michael Svihra (r)  
Fairfield, G. Gresham Griggs (r); Dimill L. Kinnie (r)  
Greenwich, Martha A. McKeehan (r); Milo A. Mitchell (r)  
Monroe, Stuart A. Upson (r)  
New Canaan, Ira E. Hicks (r); Mansfield D. Sprague (r)  
New Fairfield, Clarissa Nevius (r)  
Newtown, Newton M. Curtis (r); John F. Holian (d)  
Norwalk, Louis A. Lemaire (r); Louis J. Padula (r)  
Redding, Harold Iles (r); Adella R. Sturges (r)  
Ridgefield, Harold E. Finch (r); Peter A. McManus (r)  
Shelton, William W. Cook (r); Andrew M. Johnson, Jr. (r)  
Sherman, Howard A. Hueston (r)  
Stamford, Melvin M. Dichter (r); Edna A. F. Edgerton (r)  
Stratford, Oscar Peterson, Jr. (r); Rose E. Prokop (r)  
Trumbull, George A. Clark (r); Anna E. Griffin (r)

Weston, Chester G. Coley (r)  
Westport, Hereward Wake (r); Helen H. Warnock (r)  
Wilton, Lawrence Moore (r)  
36 Republicans, 2 Democrats

WINDHAM COUNTY  
Ashford, John Juhasz, Jr. (d); Gordon P. Whitehouse (r)  
Brooklyn, Ralph G. Ingalls (r)  
Canterbury, Nelson L. Carpenter (r); Alexander Ritzi (r)  
Chaplin, Alvah W. Miller (r)  
Eastford, Herold W. Barrett (r)  
Hampton, George Ramsey (r)  
Killingly, Albert J. Cavanagh (d); Arthur Perreault (r)  
Plainfield, Adelard LaFlesh (d); Edward T. Dion (d)  
Pomfret, J. Ellis Pritchard (r); Oren A. Weeks (r)  
Putnam, Edmond B. Gagne (r); Arthur S. Kaminsky (r)  
Scotland, Henry W. Clark (r)  
Sterling, James H. Marriott (r)  
Thompson, Raymond L. Donnelly (d); Wilfred LaFleur (d)  
Windham, Florimond J. Bergeron (d); Napoleon C. Bortolan (d)  
Woodstock, Henry D. Baker (r); Donald B. Williams (r)  
16 Republicans, 8 Democrats

TOLLAND COUNTY  
Andover, James H. Hendry (r)  
Bolton, Ralph Q. Broll (r)  
Columbia, Horace S. Holt (r)  
Coventry, Leon H. Austin (r); George G. Jacobson (r)  
Ellington, Simon S. Cohen (r)  
Hebron, Fitch N. Jones (d); Edward M. Pomprowicz (d)  
Mansfield, Charles G. Hall (r); Edwin O. Smith (r)  
Somers, Oliver C. Pease (r); Gertrude P. Wood (r)  
Stafford, Attilio R. Frassinelli (d); John H. Mullen (r)  
Tolland, Harwood J. Skelly (r); Rupert B. West (r)  
Union, George P. Hall (r); Raymond I. Longley (r)  
Vernon, Philip M. Howe (r); Harry H. Lugg (r)  
Willington, Raymond L. Squires (r); Charles F. Wochomurka (r)  
19 Republicans, 3 Democrats

Total	
Republicans	228
Democrats	44
<hr/>	
	272

**Progress Under Hill-Burton Bill**  
The Hospital Survey and Construction Act, authorizing a nationwide program of hospital construction, requires that standards of construction and equipment be established by the Surgeon General, U. S. Public Health Service. These standards will apply to all projects to be built with Federal assistance under this legislation.  
Such standards have recently been drafted by the Office of Technical Services, Division of Hospital Facilities, U. S. Public Health Service, of which Marshall Shaffer is chief. The Committee on Hospitalization and Public Health of the American Institute of Architects approved the standards and submitted them to a special technical committee on architectural standards appointed by the Federal Hospital Council.  
This committee, which met in Washington on November 12 and 13, includes in its membership James R. Edmunds, president, American Institute of Architects, chairman; Dr. Claude Munger, director,

St. Luke's Hospital, New York; Dr. Frank F. Tallman, Committee of Mental Hygiene, Department of Public Welfare, Ohio; Dr. Warren P. Morrill, director of research, American Hospital Association; Dr. Ralph Horton, director, Homer Folks Tuberculosis Hospital, Oneonta, New York; William A. Riley, Architect, Boston; and A. N. Langius, director, Building and Construction Division, State Administrative Board, Michigan.  
After review and approval by this committee, the standards were accepted by the Federal Hospital Council. These standards will be incorporated in the Rules and Regulations of the Hospital Facilities Division. The Surgeon General and the Federal Security Administrator will have to approve the Rules and Regulations before they are published and made available to all persons interested in this program. It is hoped that they will be ready before December 31, 1946.  
The standards established constitute the minimum requirements considered necessary to insure prop-

erly planned and well constructed hospitals and health centers. But since they are minimum requirements, it is pointed out that they should form a basis only for the development of higher standards.

There has been no attempt, in establishing these standards, to make them coincide with all of the various State and local codes and regulations. However, strict compliance with all applicable State and local regulations is required. Likewise, compliance is required with minimum standards of construction and equipment promulgated by the State agency administering this program, where such standards are higher than those established by the Surgeon General.

In general, these standards fall into five classifications: site, architectural, structural, mechanical and drawing and specifications. The architectural standards cover the following types of projects: general, tuberculosis, mental psychiatric and chronic disease hospitals; nurses' homes; schools of nursing; public health centers and state public health laboratories. The mechanical standards cover heating, steam piping and ventilation; plumbing and drainage; electrical; elevators and dumbwaiters; refrigeration; kitchen equipment and laundry.

### Progress Report of Child Health Survey to November 30, 1946

The Connecticut Branch of the National Study of Child Health Services sponsored by the American Academy of Pediatrics is about to begin its eighth month of survey activities, which seems a logical time to report progress to date.

Connecticut, as other states, is finding this assignment much greater in scope than originally anticipated when the Study was in the planning stage or even later in its first phases of development.

Schedules which will give specific and factual information on the various phases of child health services, such as medical care, dental care, hospital and outpatient facilities and specialized and clinical services, have been sent out.

To date all pediatricians in the State, as per listing of June 1, 1946, have had their detailed four consecutive week schedules. During the past months the pediatricians have been personally visited for additional information indicated in specialized phases of their work. One hundred and twelve pediatricians comprised the original list. At present, returns are filed for 89 pediatricians (80 per cent).

In the course of the first analysis, it was found that some of these pediatricians have changed their specialty or are practicing in other areas. A new listing is being compiled which is to include pediatricians recently returning from military service, coming into Connecticut to establish practice, or any pediatrician omitted from the original list.

Physicians in general practice and other specialties have been sent schedules in order to estimate the amount of medical care given to children under 15 years of age by other than pediatricians. At the present time, 2,409 schedules have been mailed to physicians and about 42 per cent have been returned.

Thirteen hundred and seventy-one dentists practicing in the State have been sent schedules and approximately 39 per cent of the dental schedules have been returned at this reporting. Schedules continue to come in every mail so this percentage varies from day to day.

Hospitals are grouped for this Study as general, pediatric and maternity hospitals of twenty-five beds or over and those less than twenty-five beds. The first group are the hospital schedules for which pediatricians are taking responsibility for gathering the specific information regarding facilities for child care. According to our first classification there are fifty in the first group of which 30 per cent of schedules have been returned.

In addition to the above classification, other specialized hospitals are classified as tuberculosis, nervous and mental diseases, contagious diseases, chronic and convalescent care hospitals and nursing homes. The latter are classified similarly to the hospital classification, but in this area the survey is barely started. However, all are being studied for child care facilities regardless of whether they are privately owned or tax supported institutions.

Another large phase of the present study is the Survey of Public Health Services available for children. Health officers throughout the State are aiding the Academy in getting this information. To date, this study is under way in the thirteen health jurisdictions which have full time health officers. One hundred and seventy-seven more schedules have been sent out to the part time health officers in the State.

In Connecticut there has been excellent cooperation and demonstrable willingness on the part of all individuals and organizations to do their part to make this a successful undertaking.



It is the aim of The Connecticut Survey, to have returns listed as near 100 per cent as possible. For this reason, duplicate schedules are being sent to all physicians and dentists whose original schedules were not returned to the survey office. If every physician and dentist in Connecticut will feel personal responsibility in filling out, and returning the schedules sent to them, full credit will be given to the State of Connecticut for all existing medical and dental care available for the child population in this State.

### Compulsory Retirement

Compulsory retirement on a calendar age basis should be abandoned, according to Theodore G. Klumpp, M.D., president of Winthrop Chemical Company.

Noting that the adult population was steadily increasing in proportion to the total population, Dr. Klumpp predicted that by 1980 "there will be not less than 60,000,000 American forty-five years and over and more than 21,000,000 who are sixty-five and over."

Speaking before the American Public Health Association recently, Dr. Klumpp said:

"Society has been quite illogical and inconsistent in its attitude toward the older worker. On the one hand, we have no objection to electing and appointing older individuals to positions of the greatest responsibility in government, business and the professions. And yet, as far as the rank and file of workers is concerned, we impose blind, and unselected compulsory retirement rules which automatically eliminate those in the ranks who have reached a certain age regardless of their fitness, ability and contribution to the group for which they labor."

Recognizing the social problems implicit in the increase in the adult population, Dr. Klumpp offered this 7-point program:

1. Since physiological age is not synonymous with chronological age, compulsory retirement on a calendar age basis should be abandoned.
2. Since hiring is selective and based on fitness to do a given job, retirement should likewise be selective and based on unfitness.
3. Compulsory retirement should be based on the recommendation of a retirement board composed of medical and psychiatric members as well as administrative officials.
4. If wage in proportion to performance is recog-

nized as a fundamental principle, the older worker should taper off in industry, just as the young apprentice gradually works himself up in skill, performance and remuneration. In other words, opportunities for down-grading in position and salary should be offered.

5. Industry, governmental and private institutions must make a greater and more intelligent effort to employ partially disabled persons.

6. When the aged and disabled have work to do they are less of a burden, financially, socially and spiritually to the folks at home. Other things being equal, home environment is better than an institution for the aged and disabled.

7. Institutions for the aged and disabled must be changed from asylums to modern institutions where every convenience and scientific development is available for their physical, mental and spiritual comfort.

### British Physicians and Sickness Insurance

Some day perhaps the truth will be known about what the medical profession in England thinks of sickness insurance. There have been many conflicting reports. American radicals and advocates of sickness insurance for this country have insisted that British physicians like to operate under sickness insurance, that the tight little island of Britain is a medical Utopia under the National Health Act and only a bitter little band of Tories oppose it. Other reports have not been quite so bright. Evidence grows that all is not well between the British medical profession and the Government which now proposes to nationalize medical care and hospital service.

The British Medical Association has addressed a letter to all physicians asking whether the Association should even agree to discuss the questions involved or whether the divergence between the Governments' plan and the professions' principles are so great that discussions would be fruitless. Going a step further the *British Medical Journal* has suggested that the Act would be inoperable if physicians refused to negotiate with the Government and new legislation would be necessary. The *Journal* states: "It is, of course, obvious that if the medical profession was so set against the Act that it felt unable to work under it, such a decision would in no sense be illegal or in the nature of a strike." That is a nice philosophical quibble but it is clear that if the physicians of Britain refuse to serve the sick in the system set up by the Atlee Government, then the system will not work. It looks as if that was what might happen.

## Army Reports on Use of Streptomycin

The new anti-infection agent, streptomycin, which is in the same general class as penicillin, appears effective in appropriate doses against more than half the infective bacterial organisms ordinarily encountered by surgeons, according to the report to The Surgeon General's Office from the Halloran General Hospital. Clinical studies of the use of the drug throughout the Army have been submitted and evaluated at Halloran.

On the other hand, it apparently has specific poisonous effects when given over an extended period, and bacteria soon become resistant to it so that it probably can be used only once with maximum effect within a limited period on the same patient.

The drug became available only late in the war and is still scarce and expensive.

Army experience with the drug is probably the most extensive to date due to the ability to compile and follow results. Outside the services because of limited opportunities to observe results in large numbers there have been varied, and sometimes quite exaggerated, reports on its value and it often is referred to popularly as a "miracle drug." From the first, careful observations of its effects have been carried out by Army doctors by orders of The Surgeon General, and these are being continued. The findings to date are summarized in the Army Medical Bulletin of November 1946.

The observation of the ability of bacteria to develop resistance to the drug after a few days may be of particular importance at this time. The same has been noted in respect to both the sulfa drugs and penicillin, but apparently the phenomenon is more pronounced with streptomycin. In at least one case, test tube experiments showed, there was a 100-fold increase of the resistance of an organism in ten days. Given indiscriminately, the drug may lose any value for a particular type of infection in an individual for the rest of his life. Improper use may cause variation and selection in disease agents so that streptomycin is no longer effective for the infection where it is of greatest value at the present time.

Bacteria, on the basis of certain chemical reactions, ordinarily are divided into two classes—gram positive and gram negative. The new drug, in test tube experiments, seems effective in varying concentrations, against 60 per cent gram positive and 80 per cent gram negative organisms ordinarily encountered in surgery.

Of paramount importance, is determination whether a specific micro-organism is susceptible to the drug before it is administered by mouth, by injection, or direct application.

The Army experience bears out previous claims that streptomycin is of especial value in clearing up infections of the urinary tract, provided that the organisms causing the infections are susceptible ones. If the treatment is not entirely effective in three days ordinarily no good results can be expected from its continuation. In gonorrheal infection which has proved resistant to both sulfadiazine and penicillin outstanding results have been obtained.

Use in Army hospitals gives no support to claims that the drug is of value in infections of the prostate. The drug is not concentrated in that organ.

It was found to have very little value against bone infections, except when used in conjunction with surgery where there could be direct application.

Thus far streptomycin has not given dramatic results in peritonitis, but its continued use as an auxiliary treatment seems justified.

In various dysenteries due to susceptible bacteria considerable benefit has been noted, sometimes when the drug is given by mouth alone.

In septicemia—still provided that the organism responsible for the infection is a susceptible one—streptomycin has proved very effective, but it is still essential that unapproachable foci of infection be removed by surgery.

The substance has little value, so far as the Army experience goes, against typhoid fever and it is apparently of no use in controlling carriers of this disease.

In undulant fever there have been apparent clinical arrests of the infection from the combined use of streptomycin and sulfadiazine after each drug given alone had failed. Further study will be required, however, before any valid conclusions can be reported.

It is very effective against tularemia, or rabbit fever, provided the specific organism responsible has been demonstrated in test tube experiments to be susceptible to the drug.

Up to date experience with only a few cases of meningitis have been reported and the results, in conjunction with other treatments, have been quite good. The Army doctors found, however, that it must be given by injection into the space between the thick membranes surrounding the brain and



spinal cord and the brain or spinal cord tissue. Circulating in the blood stream, it cannot pass this barrier to reach the infecting organisms.

Excellent results have been obtained with direct application of the drug to infections of the external ear, the pleural cavities and the brain. Infections elsewhere will not reach local foci of infection in sufficient concentration to be effective.

One of the hopes of the medical profession has been that streptomycin would prove of some value against tuberculosis. The Army experience neither confirms nor refutes this since a much longer series of investigations will be required before there can be any valid conclusions.

Balances against the demonstrated value of streptomycin in suitable cases are some apparently toxic effects. Some of these are probably due to impurities in the drug but others seem to be specific for the drug itself. The most serious of these is what seems to be an irreversible damage to part of the eighth cranial nerve which appears when streptomycin is given in large doses by injection for more than ten days. This means that one's sense of balance may be disturbed for a long time, with possible attacks of dizziness and nausea. This was found in two Army cases. A third patient showed partial deafness, indicating that there had been a poisonous effect on the other portion of the eighth cranial nerve, which is the path of hearing. Toxic effects also were noted on the kidneys. All this demonstrated that the drug should be given only by physicians, and then only after careful consideration of the organisms involved and the safe dosage.

### Allergy Drug Presents Serious Industrial Hazard — Drowsiness

Two Rochester, N. Y., doctors warn that benadryl, a very effective drug for allergic skin diseases, is dangerous to persons operating any kind of machine, especially an automobile, because it may produce drowsiness, according to an article in the September 28 issue of *The Journal of the American Medical Association*.

Benjamin J. Slater, associate medical director, Eastman Kodak Co., and Nathan Francis, of the Medical Department of the Eastman Kodak Co., in Rochester, state that "because of this narcotic side reaction incident to the taking of benadryl, the drug may be a serious hazard when used by persons

operating automobiles or in industry operating moving equipment or machinery."

In their series of 65 cases, the authors point out that drowsiness was a common symptom in 25. "This figure should be increased somewhat," they say, "as many of our patients were instructed to take the drug only at bedtime. Invariably they reported that they slept better than usual. Drowsiness may occur from one to three hours after taking benadryl, and this drowsiness may be cumulative if the drug is continued."

A case report of one of their patients serves to illustrate how dangerous the effect of the drug may prove. A 20 year old man was given a 50 milligram capsule of this drug to relieve severe symptoms of hay fever. The second day of treatment he took the capsule just before going to work. He complained of feeling drowsy. An hour later, while driving an electric platform cargo truck, he lost control of the truck and it fell off the platform. Fortunately, he jumped in time to avoid injury.

### Postgraduate Medicine, a New Monthly Journal Appears in January 1947

A new journal of general medicine, *Postgraduate Medicine*, presenting articles of high scientific value and clinical interest with the editorial emphasis centered on treatment, will be published beginning January, 1947, announces Dr. Arthur G. Sullivan, managing director of the Interstate Postgraduate Medical Association of North America. Much of the basic material will come from the addresses and diagnostic clinics which are presented at the annual meetings of this association, but it will be supplemented by new material originating in various postgraduate centers.

In the thirty years that the Interstate Postgraduate Medical Association has been holding meetings, it has drawn an attendance of thousands of doctors. At the recent Cleveland meeting, 3,200 were registered. They came for one reason—information—refresher courses of a postgraduate caliber. Since 1925, the papers and clinics of this association have been published in one bound volume. However, of recent years paper and space limitations have restricted the size of the volume, curtailed the amount of material included in it and almost entirely prevented the use of illustrations. *Postgraduate Medicine*, which will contain these papers spaced over a year's time, will

give the doctor in permanent form the complete file of the material presented at these meetings, together with other valuable material as it develops month by month. The subscription price is \$8 per year.

### Penicillin Gonorrhea Masks Syphilis

From the U. S. Marine Hospital, Staten Island, N. Y., comes the following:

The observation is made that the occurrence of chills or fever accompanying penicillin therapy for gonorrhea not obviously complicated by syphilis is strong presumptive evidence of the coexistence of syphilis. Although there are exceptions to the rule, it appears to be a safe precaution to subject a patient displaying a febrile reaction to penicillin to close scrutiny, clinical and serologic, for a period of four months following therapy. Within that period additional evidence of an oncoming syphilis may be expected to develop.

### Shortage of Influenza Vaccine

The State Department of Health reports an apparent shortage of influenza vaccine. The Navy has reported through a Bureau of Medicine news letter a method of using 1/10 cc. intracutaneously instead of 1 cc. subcutaneously. Results showed a rise in serum antibody titer considerably greater than that following a single subcutaneous injection. The use of this intracutaneous method would increase the amount of influenza vaccine available as well as reduce the possible reactions.

### Psychiatric Leaders Organize New Foundation

Fathered by the American Psychiatric Association and sponsored by the American Neurological Society a new organization has been formed known as the Psychiatric Foundation. This new Foundation will have as its officers and directors outstanding lay leaders of the country. Leo H. Bartemeier of Detroit, secretary-treasurer of the American Psychiatric Association heads the medical men designated to assume responsibility during the period of organization. Included on the organizing committee is C. Charles Burlingame of Hartford.

The objectives of the Foundation fall under five heads: (1) education of members of the psychiatric team; (2) psychiatric research; (3) medical legislation; (4) child psychiatry; (5) education of the public.

### U. S. Public Health Service Allots \$2,500,000 to States; to be Used for Cancer Control

Announcement has been made by the United States Public Health Service of the allocation of \$2,500,000 to promote cancer control throughout the United States and its territories. This amount, provided for the fiscal year beginning July 1, 1946, is apportioned to each state to be expended as directed by the State Departments of Health in accordance with certain broad principles outlined by the Public Health Service.

Seeking integration of the available resources at the disposal of the United States Public Health Service and the Society, and in an attempt to co-ordinate the program of cancer expenditures, a resolution was passed by the Executive Committee of the Board of Directors of the Society at the September meeting which empowered certain officers of the Society to enter into conferences with officials of the Public Health Service and other departments of the government for the purpose of obtaining cooperation and also clarifying the Society's present objectives and past accomplishments.

The cancer control program of the Public Health Service, recently inaugurated, suggests activities in each state for which its funds might be spent. In the administrative field, the following expenditures would meet with approval: the payment of part of the office costs of the State Health officer; salary and travel expenses of the chief of the Cancer Control Division of the State Health Department and other office personnel; travel expenses for members of the Advisory Committee, consultants and clinicians; and various miscellaneous office expenses.

State-wide surveys of the cancer problem in terms of vital statistics, which would determine the availability and requirements of a state cancer program, are recommended by the Public Health Service and their funds may be granted for this purpose. Training of public health personnel and practicing physicians in the state is also advised.

Service projects for which these funds may be utilized include: epidemiological services and diagnostic and therapeutic services. These services may support a statistical unit, pay collaborating epidemiologists, maintain local tumor registries, paying for salaries, equipment and supplies for full-time or part-time pathologists, for tissue diagnostic services; establishment, operation and maintenance of fixed



and mobile cancer detection clinics, paying for diagnostic procedures, x-ray or biopsy; and payment for radiation therapy.

Funds cannot be used for surgical procedures or hospitalization except for diagnostic purposes nor for research excepting statistical work, nor for transportation of patients. A comprehensive questionnaire has been prepared by the Public Health Service in an effort to determine the phases of the state cancer program wherein these funds may best be utilized.

Although this \$2,500,000 grant by the Public Health Service for cancer control represents a forward step in the allotment of government funds for the cancer fight, it is but another evidence of the mounting nationwide interest in this cause. An increasing number of states by legislative action have made or are requesting in the current sessions of their law-making bodies annual appropriations for cancer control. These state appropriations take various forms; for instance, in Alabama, the funds are used to support a program of aiding and caring for indigent cancer cases and in Massachusetts public funds are assigned to support intensive statistical surveys as well as aiding needy cases.

The amount available to Connecticut from Public Health funds is \$27,566 and from State appropriations, \$64,728, according to a report from the American Cancer Society.

### Metropolitan Life Pays \$66,000,000 in War Claims

*The Statistical Bulletin* of the Metropolitan Life Insurance Company reports that \$66,000,000 has been disbursed by that company in payment of "War Claims" on about 75,000 deaths among its American and Canadian policyholders in World War II. This amount has been paid by the various departments of the Company for deaths from all causes among men in service, as well as for deaths from enemy action among civilians. The account is not quite complete, because in a number of cases claims are unavoidably delayed in being forwarded to the Company.

Deaths among insured civilians were but a small proportion of the total war deaths. In the Metropolitan's experience they amounted to about two per cent of the deaths from enemy action for the war period as a whole. However, civilian fatalities—almost entirely merchant seamen—were relatively much more prominent in the early years of the war

when heavy losses were inflicted on our merchant ships. For example, in 1942 almost one-fifth of the deaths from enemy action in this insurance experience were among civilians, as compared with one-twentieth in 1943 and a negligible proportion in both 1944 and 1945, thus reflecting the subsidence of the submarine menace.

The leading causes of death from disease among the armed forces were about the same as in a civilian group of a like age distribution. For example, among the military personnel, the leading causes of death were, in the order of their numerical importance, the diseases of the cardiovascular-renal system, influenza and pneumonia, cancer, and tuberculosis. It was only among the less common diseases that the effect of the war was at all apparent. The group of "unknown causes" was unusually high, ranking fifth in importance. This was followed by malaria, meningitis, and dysentery. Two of these—malaria and dysentery—occurred in a sizeable proportion of the cases in Japanese prison camps where medical service was altogether lacking. The remaining diseases to cause any appreciable number of deaths were appendicitis, leukemia, and "other diseases of the liver." The mortality from disease among Metropolitan policyholders in service was low, the rate being not more than 0.5 per 1,000 per annum.

### Army Medical Library Consultants Press Plans for New Building

At meetings in Washington on October 4 and 5, 1946, the Association of Honorary Consultants to the Army Medical Library urged early action for a new library building. Major General Norman T. Kirk, The Surgeon General of the Army, at a dinner for the members of the Association, said that it was planned to ask Congress at the next session for enabling legislation to build the library and that it was hoped to include the request for funds in the 1948 budget. The 110 year old library is now housed in a non fireproof structure which was built in 1887. Other addresses at the dinner, which was presided over by Dr. John F. Fulton, professor of physiology of Yale University and president of the Association, were given by Colonel Leon L. Gardner, the director of the library; professor Max H. Fisch, University of Illinois, former chief of the Medical History Division, Army Medical Library; and Dr. Reginald Fitz, lecturer on Historical Medicine, Harvard University.

## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*  
 EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven  
 JOSEPH N. D'ESOP, New Haven

#### Program of Home Town Medical Care

Paul R. Hawley, M.D., medical director of Veterans Administration, has explained the extent of the medical services which may be rendered to veterans under VA's home-town medical care program.

Under existing legislation, veterans may be furnished outpatient medical or dental treatment in VA clinics, in private offices of physicians or dentists or in their own homes *only for disabilities recognized by VA as incurred or aggravated in line of duty in active service*, Dr. Hawley emphasized.

He added that only prescriptions for service-connected disabilities may be filled at government expense by local pharmacies under VA's home-town prescription service.

The medical facilities of VA regional and sub-regional offices, clinics and hospitals, under law must be utilized to the fullest extent for examination and out-patient treatment of veterans.

When determining whether a veteran, residing in an area where there is a VA field station (clinic, hospital, etc.), is to be referred to a VA clinic or to a civilian physician, the best interests of both the veteran and the government will be considered.

Although VA medical facilities must be utilized to their fullest extent, this does not mean that veterans will arbitrarily be ordered to field stations.

If veterans establish to the satisfaction of the chief medical officer of a VA regional office that reporting to a field station would work unnecessary physical hardship or cause excessive loss of time from employment, fee-basis doctors may be utilized. In any event, final decision rests with chief medical officers of VA regional offices.

Then too, when the backlog of physical examinations justifies or when outpatient treatment is not being rendered expeditiously, the chief medical officers of VA regional offices may utilize the services of civilian physicians working under statewide contracts with VA.

Male veterans may be admitted to private hospitals (preferably those under contract by VA) for inpatient treatment of *service-connected* disabilities by civilian physicians under contract to VA only if their condition is such as to constitute an emergency which cannot be met by a VA hospital because of the lack of beds or because the patient's condition prohibits travel.

Prior authorization for this hospitalization and treatment in a private hospital must be obtained by letter, telephone or telegraph. If, owing to the extreme emergency of the case, prior authorization is not obtained, the physician or admitting hospital should notify VA within 72 hours. If the facts so warrant, VA will then issue authority for the veteran's private hospitalization and treatment.

Women war veterans may be admitted to private hospitals (preferably those under contract by VA) for inpatient treatment of *both service-connected and non service-connected disabilities* by civilian physicians if it is an emergency which cannot be met by VA or because of the unavailability of beds or because the serious condition of the patient precludes travel. Authorization must be obtained exactly as in the case of male veterans.

#### Special Orthopedic Shoes for Veterans

Veterans with service-connected disabilities now may obtain special orthopedic shoes free of charge from Veterans Administration, Dr. Paul R. Hawley, chief of VA's medical service, announced recently.

A number of machines to make plaster casts of injured or deformed feet have been transferred from the War Department to VA and two are already in operation—at the VA hospital, Hines, Illinois, and at VA's hospital at Atlanta, Georgia, formerly the Army's Lawson General hospital.

The machines also will be installed at VA regional offices in Kansas City, Missouri; New York, N. Y.; and San Francisco, California, and will be in operation on dates to be announced later.



Plaster casts made by these machines will be sent to the Army's Quartermaster Supply depot at Boston, Mass., where special lasts and patterns will be developed.

The orthopedic shoes then will be constructed by commercial contractors and completed shoes will be shipped to veterans by the VA regional office or hospital making the purchase.

Qualified veterans and also Army personnel will be eligible for the service, either at Army establishments where the cast-making machines are in operation or at VA hospitals or regional offices where the machines are in operation or where they are scheduled to go in operation within the next few months.

Veterans should make applications through their nearest VA representative.

Cast-making machines are maintained by the Army at: Orthopedic Footwear Clinic, Boston, Mass.; Walter Reed General Hospital, Washington, D. C.; Brooke Army Medical Center, Fort Sam Houston, Texas; Fitzsimmons General Hospital, Denver, Colorado; Madigan General Hospital, Fort Lewis, Washington.

### Total Disability Insurance

Veterans Administration has reminded veterans who have National Service Life Insurance that they now may be insured against total disability.

Total disability income benefits authorized by recent legislation may be added to any plan of NSLI upon application, proof of good health, and payment of an extra premium, VA said.

Premium rates for the disability coverage range from 6 cents to 94 cents a month per \$1,000 of insurance, depending on the insured's age and type of policy.

The disability benefits are at the rate of \$5 a month for each \$1,000 of insurance and are payable after the veteran has been totally disabled continuously for six months or more. The monthly benefits will continue to be paid as long as the insured remains totally disabled. However, the disability must commence before the veteran's sixtieth birthday.

One of the principal features of the new disability benefit, VA officials said, is that the face value of the veteran's policy will not be reduced by any disability payments that he might receive.

VA said that veterans with service-connected disabilities less than total in degree are not prevented

from taking advantage of the new provision, provided they apply for it before January 1, 1950. In these cases, such disabilities are waived if they are the only bar to meeting the health requirements.

Veterans who wish to obtain full information regarding the new disability income feature should contact their nearest VA office.

### Veterans Administration

The authorized hospital capacity of Veterans Administration has passed the 100,000 bed mark for the first time in history.

VA said the new record was set with the recent acquisition of six more Army and Navy hospitals in the program to provide beds for the increasing number of veterans who need hospitalization while VA's big hospital construction project is in progress.

The six recently acquired service hospitals are Cushing General, Framingham, Mass.; Fort Logan, Colo.; Billings General, Fort Harrison, Ind.; Newton D. Baker, Martinsburg, W. Va.; Moore General, Swannanoa, N. C.; and the Naval hospital at San Juan, Puerto Rico.

This makes 28 former Army and Navy hospitals now being operated by VA, either as permanent or temporary installations pending the completion of the hospital construction program.

Most of the veterans awaiting hospitalization are non service-connected cases. On November 1, they numbered 25,127, against only 73 service-connected cases.

Under the law, VA is required to hospitalize service-connected cases as quickly as possible, but to provide hospital care for non service-connected cases only when beds are available. All emergency cases are handled immediately.

Since the veterans' need for hospitalization has constantly exceeded VA's bed capacity during the last year, the federal agency was forced to hospitalize 13,140 veterans in non VA hospitals up to October 30.

### P. O. Department Changes Ruling on Contraception

During 1946 the Post Office Department rescinded the ban on the mailing of contraceptive materials and contraceptive information. Henceforth such material may be mailed but only in envelopes on which the name of a physician appears.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, MRS. JAMES DOUGLAS GOLD, Bridgeport  
*President-Elect*, MRS. ALFRED LABENSKY, New London  
*First Vice-President*, MRS. FREDERIC W. WERSEBE, Washington  
*Second Vice-President*, MRS. JAMES RAGLAN MILLER, Hartford

*Recording Secretary*, MRS. CHARLES W. GOFF, West Hartford  
*Corresponding Secretary*, MRS. EDWIN R. CONNORS, Bridgeport  
*Treasurer*, MRS. FRANK DiSTASIO, New Haven

### Health Begins at Home

The interest of every American in maintaining his health and the health of his family properly begins at home.

It is at home that children should learn the first principles of health protection. This is not a new process. It has been going on for years in the majority of America's homes.

In the current high interest in national health problems, with adults unwisely in many cases allowing themselves to be swayed by Shangri-La promises of health through politics, the fundamental truth that health should begin at home sometimes gleams but darkly.

It is time that American parents re-evaluate the basic role they play in the education of their children for health, direct their efforts toward this end, and stop listening to the swan songs of political opportunists.

In promoting this sound development, *Hygeia*, the national health magazine of the American Medical Association, has become a major factor. Started in 1923 with a circulation of slightly more than 20,000 copies, this publication now distributes more than 200,000 copies each month to schools, social organizations, hospitals, commercial enterprises, physicians, dentists, nurses, and teachers.

Containing authentic health information written in non technical language easy for anyone to understand, the promotion of this successful modern periodical is an activity of which all participants can be proud.

Members of the Woman's Auxiliary to the Connecticut State Medical Society last year won first place for the largest annual percentage increase in *Hygeia* circulation. This outstanding record means more than the winning of a contest; it means that additional thousands of Connecticut's citizens have access to reliable health information furnished by

qualified physician-authors.

There can be no higher devotion than that of aiding our citizens to protect their health and the health of their children.

### Hartford County

Mrs. Charles W. Goff, chairman of the Legislative Committee of the Woman's Auxiliary to the Hartford County Medical Association and her committee: Mrs. Frederick S. Ellison, Mrs. Kenneth F. Brandon, Mrs. Harold S. Backus, Mrs. Charles K. Wallace, Mrs. Thomas C. Carey, announce the following program for discussion groups. Meetings are to be held in the homes of association members at 2:00 P. M. and will be followed by a period for discussion. Tea will be served.

1. Tuesday, January 7, Mrs. Edith Valet Cook, State chairman of the Committee on Legislation of the Woman's Auxiliary to the Connecticut State Medical Society. Topic: "An Outline of Practical Workings in Politics." The meeting will be at the home of Mrs. James Raglan Miller, 248 North Whitney Street, Hartford.

2. Tuesday, February 4, Dr. Grace Mooney, executive assistant to the Connecticut State Medical Society. Topic: "Recent Developments in National Legislation." The meeting will be at the home of Mrs. J. Whitfield Larrabee, 54 Walbridge Road, West Hartford.

3. Tuesday, March 4, James Raglan Miller, M.D., president-elect of the Connecticut State Medical Society and a member of the Board of Trustees of the American Medical Association. Topic: "Connecticut Health Legislation and the Connecticut Plan for Voluntary Insurance." The place of meeting will be announced later.

Mrs. Paul S. Phelps, president, and Mrs. Norman J. Barker, hospitality chairman, will pour at the January 7 tea.



## Litchfield County

A luncheon and meeting of the Woman's Auxiliary to the Litchfield County Medical Association was held at the home of Mrs. F. L. Polito, Torrington Avenue, Torrington, November 12, 1946, with the president, Mrs. Polito, in the chair. She gave a report on several state meetings she had attended recently.

Mrs. James Gold of Bridgeport, State president, spoke on socialized medicine.

Mrs. James Raglan Miller of Hartford, second vice-president and program chairman of the State Auxiliary, said that the State Society stands ready with program material to enlighten the public as to what the doctors are doing. She also stressed study groups.

Miss Pauline Crandall, supervisor of Child Welfare Service in Litchfield County, gave a talk on the work and problems of the social welfare needs of Litchfield County. She gave the history of public welfare of Connecticut and also a summary of child welfare programs under the Social Security Act. The interesting talk was concluded with the philosophy of working with children in their own homes.

There was an attendance of about thirty-five members.

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## THE DOCTOR'S OFFICE

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Pinckney W. Snelling, M.D., announces that Charles A. Tucker, M.D., is associated with him in the practice of otolaryngology, 179 Allyn Street, Hartford.

Thomas Keery Merwin, M.D., wishes to announce that he is practicing ophthalmology in association with Michael H. Gill, M.D., 36 Pearl Street, Hartford.

William B. Smith, M.D., announces his return from military service and the opening of his office, 80 Farmington Avenue, Hartford. Practice limited to cutaneous medicine.

Maxwell Pasternak, M.D., announces the opening of his office for the practice of psychiatry at 235 Bishop Street, New Haven.

Milton S. Godfried, M.D., announces the removal of his office to 85 Trumbull Street, New Haven. Practice limited to gynecology and obstetrics.

Vincent J. Cavaliere, M.D., released from the Army Medical Corps in July with the rank of Captain, has opened an office at 634 Washington Avenue, Bridgeport.

Leonard C. Veneruso, M.D., formerly Captain, MC-USA, has opened an office for the general practice of medicine at 1690 Barnum Avenue, Bridgeport.

Joseph A. Chiota, M.D., announces that he is resuming the practice of general surgery with an office at 562 Boston Avenue, Bridgeport.

Frank F. Northman, M.D., announces the opening of an office at 1884 Park Avenue, Bridgeport.

Robert B. Boyd, M.D., has entered upon the practice of medicine in Meriden in association with Drs. Charles A. Breck and James F. Ferguson, Jr., at 176 North Main Street.

Theodore Rosen, M.D., announces the opening of an office at 829 Main Street, Manchester, for the treatment of diseases of the eye, ear, nose and throat.

Joseph M. Wool, M.D., has returned to New London and will be associated with Dr. Charles Kaufman, local medical examiner, in the general practice of medicine.

Robert E. Malone, M.D., has returned from military service and resumed the practice of medicine and surgery at 157 Gulf Street, Milford.

Luke J. Cerrone, M.D., has resumed the practice of medicine at 67 Chapel Street, New Haven, after four years in the U. S. Army.

Joseph S. Riccio, M.D., will resume the practice of medicine and surgery at 1059 Dixwell Avenue, New Haven.

Dexter Wolfson, M.D., has been released from the Army Medical Corps and has resumed his practice in Bethel.

David Galinsky, M.D., announces his return to practice at 57 Wethersfield Avenue, Hartford. Practice limited to gastroenterology and gastroscopy.

Maurice M. Pike, M.D., having returned from military service, announces the association of John Whitefield Larrabee, M.D., in the practice of orthopedic surgery with offices located at 64 Garden Street, Hartford 5.

Max R. Goldstein, M.D., announces the opening of his office for the practice of internal medicine at 44 Garden Street, Hartford.

Morgan Y. Swirsky, M.D., having returned from military service, announces the opening of his office at 1204 Chapel Street, New Haven, for the practice of internal medicine.

## SPECIAL NOTICES

### ANNOUNCEMENT OF A POSTGRADUATE COURSE ON INDUSTRIAL MEDICINE TO BE GIVEN UNDER THE AUSPICES OF THE YALE INSTITUTE OF OCCUPATIONAL MEDICINE AND HYGIENE AT THE YALE UNIVERSITY SCHOOL OF MEDICINE FEBRUARY 4 — APRIL 8, 1947

Sessions will be held from 4:00 to 5:30 P. M., Brady Amphitheatre. Entrance at 310 Cedar Street.

This course is open without charge, to all physicians, particularly those engaged in full-time or part-time industrial practice.

Inquiries and reservations should be addressed to Dr. R. F. Buchan, Yale Institute of Occupational Medicine and Hygiene, 310 Cedar Street, New Haven, Connecticut.

#### FEBRUARY 4—COMMONLY ENCOUNTERED TOXICOLOGICAL PROBLEMS

Principal Speaker—Dr. John H. Foulger, director, Haskell Laboratory of Industrial Toxicology, Wilmington, Delaware

Chairman—Dr. Alice Hamilton, formerly assistant professor of Industrial Medicine, Harvard Medical School; formerly special investigator of Poisonous Industries for the U. S. Bureau of Labor Statistics; author "Industrial Poisons in the U. S." and "Industrial Toxicology"

Chairman—Dr. M. J. Strauss, clinical professor of dermatology, Yale University Medical School

#### FEBRUARY 25—THE HAND IN INDUSTRY

Principal Speaker—Open

Chairman—Dr. Samuel Harvey, professor of surgery, Yale University Medical School

#### MARCH 4—THE INDUSTRIAL PHYSICIAN'S RESPONSIBILITY UNDER THE COMPENSATION LAW

Principal Speaker—Open

Chairman—Professor Harry Shulman, professor of law, Yale University Law School

#### FEBRUARY 11—INDUSTRIAL HYGIENE: ITS MODERN CONCEPT

Principal Speakers—Dr. Albert S. Gray, director, Bureau of Industrial Hygiene, Connecticut State Department of Health

Mr. Allan Coleman, chief industrial hygienist, Bureau of Industrial Hygiene, Connecticut State Department of Health

#### MARCH 11—PATTERN FOR DIAGNOSIS OF BEHAVIOR IN INDUSTRIAL RELATIONS

Principal Speaker—Dr. E. Wight Bakke, director, Labor and Management Center, Yale University

Chairman—Dr. Warren T. Brown, assistant professor of mental hygiene and psychiatry, department of Psychiatry and Mental Hygiene, Yale University Medical School

#### FEBRUARY 18—DIAGNOSIS AND THERAPY OF INDUSTRIAL DERMATOSES

Principal Speaker—Dr. Louis Tulipan, clinical professor of Dermatology and Syphilology, New York University College of Medicine; co-author "Occupational Disease of the Skin" (Schwartz and Tulipan)

#### MARCH 18—TOXIC AND NUISANCE DUSTS IN INDUSTRY

Principal Speaker—Open

Chairman—Dr. Dudley A. Irwin, medical director Aluminum Company of America, Pittsburgh, Pennsylvania



## MARCH 25—VISION IN INDUSTRY

Principal Speaker—Dr. Hedwig S. Kuhn

## APRIL 1—RADIOACTIVITY, HEALTH AND SAFETY

Principal Speaker—Dr. Stafford Warren, formerly Colonel, U. S. Army Medical Corps; formerly medical director, Manhattan Project, Corps of Engineers and now consultant to that project; professor of radiology, School of Medicine and Dentistry, University of Rochester, Rochester, New York

Chairman—Dr. Averill A. Liebow, assistant clinical professor of pathology, Yale University Medical School

## APRIL 8—FACILITIES FOR REHABILITATION OF THE INJURED AND PHYSICALLY HANDICAPPED WORKER

Principal Speaker—Dr. Howard A. Rusk, formerly chief of Rehabilitation Service, U. S. Army Air Force; director, Department of Rehabilitation and Physical Medicine, New York University; associate editor, *New York Times*

Chairman—Dr. A. J. Lanza, associate medical director, Metropolitan Life Insurance Company, New York City

# YALE SCHOOL OF MEDICINE SEMINARS AND CONFERENCES OPEN TO CONNECTICUT PHYSICIANS DURING THE SCHOOL YEAR

## DAILY

Clinic of Child Development—Developmental examinations and conferences

14 Davenport Avenue

Operative Clinics

Farnam Operating Rooms

## MONDAYS

Course in Traumatic Surgery

4:30 P. M. Farnam Auditorium

Clinical Pathological Conference

4:00 P. M. Fitkin Amphitheater

Pediatrics—Clinic for 3rd and 4th year students

12:00 M. Fitkin Amphitheater

## TUESDAYS

Neurological Study Unit

4:30 P. M. Fitkin Amphitheater

Obstetrics-Gynecology—Clinical Conference

12:00 M. Farnam Auditorium

Pathology—Staff Microscopic Demonstrations

9:00 A. M. Brady Laboratory

Radiology Conference—Urological-Radiological

4:00 P. M. Dept. of Radiology

Tumor Conference

1:30 P. M. Farnam Auditorium

## WEDNESDAYS

Case Conference in Surgery

8:00 A. M. Farnam Auditorium

Clinical Pathological Conference for students

4:30 P. M. Brady Auditorium

Pediatrics—Clinic for staff and visitors

12:00 M. Trask Memorial Room

Physiological Chemistry—Seminar 2:00 P. M.

C105 Sterling Hall of Medicine

Preventive Medicine and Public Health—Conference

10:00 A. M. Fitkin Amphitheater

Psychiatry—Staff Conference

9:00 A. M. 305 Institute of Human Relations

Radiology Conference—Radiological-Therapy

3:00 P. M. Dept. of Radiology

Radiology Conference—Radiological Diagnosis

4:00 P. M. Dept. of Radiology

Surgery—Clinic

12:00 M. Farnam Auditorium

(second Wednesday of each month)

Yale Medical Society

8:00 P. M. Brady Auditorium

## THURSDAYS

Medicine—Clinic for 3rd and 4th year students

12:00 M. Fitkin Amphitheater

Pathology—Surgical Pathology Slide Demonstrations

Surgical Pathology Laboratory

Pharmacology—Seminar

4:10 P. M. B203 Sterling Hall of Medicine

Physiological Chemistry—Nutrition Journal Club

12:30 P. M. B333 Sterling Hall of Medicine

Radiology Conference—Medical-Radiological

4:00 P. M. Dept. of Radiology

## FRIDAYS

Chest Conference

4:00 P. M. Fitkin Amphitheater

Neuro-Anatomy—Conference in Comparative Neurology

11:00 A. M. B240 Sterling Hall of Medicine

Psychiatry—Clinic

12:00 M. Fitkin Amphitheater

Public Health—Seminar

4:15 P. M. Blue Room, Institute of Human Relations

Radiology Conference—Neurological-Radiological

3:00 P. M. Dept. of Radiology

Radiology Conference—Thoracic-Radiological

4:00 P. M. Dept. of Radiology

## SATURDAYS

Medical Staff Conference

11:00 A. M. Fitkin Amphitheater

## NATIONAL CONFERENCE ON MEDICAL SERVICE

The 20th Annual Meeting of the National Conference on Medical Service will be held at the Palmer House, Chicago, Illinois, on February 9. Registration will commence at 9:00 A. M. and the program will include discussions in the fields of

national affairs, economics and medical education. All physicians are invited to attend, there is no registration fee. Dr. Cleon A. Nafe, Indianapolis, is president of the Conference and Creighton Barker, New Haven, is the secretary.

### SPECIALIST EXAMINATIONS

The U. S. Civil Service Commission has announced an examination for Medical Officer (Specialist) which will be used to fill high-grade positions in various medical fields. These positions are located in Washington, D. C., and vicinity.

Salaries for these positions range from \$7,102 to \$9,975 a year. To qualify, applicants must be graduates of a medical school with the degree of doctor of medicine. In addition they must have had progressively responsible experience or education in a specialized medical field. For some positions applicants must also be currently licensed to practice medicine and surgery in the United States or its Territories. The maximum age limit, sixty-two years, will be waived for persons entitled to veteran preference. Further information regarding the requirements is contained in an inclosed Examining Circular.

As the positions to be filled from the Medical Officer (Specialist) examination are of a highly technical and specialized nature, selective publicity is being used to bring the examination to the attention of persons with the necessary qualifications. It is believed that you or other members of your organization may be interested in the examination or know of other persons who are qualified. Your cooperation in informing such persons of this opportunity for Federal employment, or in submitting their names to this office to be sent copies of the circular, will be greatly appreciated.

Interested persons may secure application forms from most first- and second-class post offices, from Civil Service regional offices, or from the Commission's central office in Washington, D. C. Applications will be accepted by the Civil Service Commission until further notice.

### DIRECTORY OF CONVALESCENT HOMES

The Committee on Public Health Relations of The New York Academy of Medicine is preparing a new edition of the "Directory of Convalescent Homes in the United States," to be published by the Sturgis Fund of the Winifred Master-son Burke Relief Foundation of White Plains, New York. The last issue of this Directory was published by the Sturgis Fund in 1931 under the auspices of the Committee on Convalescent Care of the American Conference on Hospital Service and has long been out of print. The need of a new directory is recognized by all concerned.

Early in January, a questionnaire will be distributed to all recognized convalescent homes maintained by municipalities, counties or voluntary bodies. The information sought deals with the physical plant, the staff, the requirements for admission, the type of patients, therapy, and such other matters as will make the Directory a dependable guide for physicians who wish to refer their patients to institutions for convalescence. The questionnaire is so devised that it can be filled out with a minimum of effort. Convalescent homes that do not receive a questionnaire are urged to request one by

writing to E. H. L. Corwin, executive secretary, Committee on Public Health Relations, The New York Academy of Medicine 2 East 103rd Street, New York 29, New York.

### PUBLIC HEALTH FELLOWSHIPS

Fellowships leading to a Master's Degree in Public Health in the field of Health Education are being offered to any qualified United States citizen between the ages of 22 and 40, according to a statement by the United States Public Health Service, Federal Security Agency. Tuition, travel expenses for field training and a stipend of \$100 a month will be provided out of funds furnished by the National Foundation for Infantile Paralysis.

Candidates must hold a bachelor's degree from a recognized college or university and must be able to meet the entrance requirements of the accredited school of public health of their choice. In addition to the degree, courses in the biological sciences, sociology, and education may be required. Training in public speaking, journalism, psychology, and work in public health or a related field are considered desirable qualifications.

The year's training, which begins with the 1947 fall term, consists of eight or nine months academic work including: public health administration, epidemiology, public health and school education, problems in health education, community organization, and information techniques; and three months of supervised field experience in community health education activities.

Application blanks may be obtained by writing the Surgeon General, United States Public Health Service, Washington 25, D. C., and must be filed prior to March 15, 1947.

Veterans are encouraged to apply and will be paid the difference between their subsistence allowance under the G.I. Bill of Rights and the monthly stipend of \$100. Employees of local and state health departments are not eligible since Federal grants-in-aid are already available for such training purposes.

### MISSISSIPPI VALLEY MEDICAL SOCIETY 1947 ESSAY CONTEST

The Seventh Annual Essay Contest of the Mississippi Valley Medical Society will be held in 1947. The Society will offer a cash prize of \$100, a gold medal, and a certificate of award for the best unpublished essay on any subject of general medical interest (including medical economics and education) and practical value to the general practitioner of medicine. Certificates of merit may also be granted to the physicians whose essays are rated second and third best. Contestants must be members of the American Medical Association who are residents of the United States. The winner will be invited to present his contribution before the Twelfth Annual Meeting of the Mississippi Valley Medical Society to be held at Burlington, Iowa, October 1, 2, 3, 1947, the Society reserving the exclusive right to first publish the essay in its official publication—the *Mississippi Valley Medical Journal* (incorporating the *Radiologic Review*). All contributions shall be typewritten in English in manuscript form, submitted in five copies, not to exceed 5000 words, and must be received not later than May 1, 1947.



The winning essays in the 1946 contest appear in the January 1947 issue of the *Mississippi Valley Medical Journal* (Quincy, Illinois).

Further details may be secured from Harold Swanberg, M.D., Secretary, Mississippi Valley Medical society, 209-224 W. C. U. Building, Quincy, Illinois.

### PHOTODUPLICATION SERVICE

Since December 1940, the Army Medical Library has been providing a free photoduplication and microfilm service on a global basis in the interest of medical research. Although there is every wish to continue this free service, present conditions do not make it practicable to do so. Wartime needs made such a service imperative, but the volume has increased to such a degree of late that a revision of policy has become advisable.

To meet these changed conditions, a decision has been reached to make a nominal charge for photoduplication service, starting 1 January 1947. On a charge basis, more film can be made available, all requests can be filled, which accord with the conclusions reached by the special committee now studying the matter under the auspices of the Honorary Consultants at the request of The Surgeon General. This move will also place the Library in line with other Federal agencies which have always charged for similar services.

The following price scale has been set up:

Microfilm: *Periodical Articles*—A flat charge of fifty cents for any article in a single volume. *Books and Serial Publications*—Fifty cents for each fifty pages or fraction thereof.

Photoprints: Fifty cents for each ten pages or fraction thereof from any single volume.

Method of Payment: All charges are on the basis of cash with order. Only Federal agencies are exempted from this requirement. Payment may be made by cash or by check or money order drawn to the Treasurer of the United States.

A supply of Order Blanks will be available on request after 15 December 1946.

### DEADLINE

May 1, 1947 is the deadline for entering the \$34,000 prize art contest on the special subject of "Courage and Devotion Beyond the Call of Duty (on the part of physicians in war and in peace)." This contest is open to all M. D.'s in the Western Hemisphere. The exhibition will take place in conjunction with the A.M.A. Centennial Session at Atlantic City, June 9-13, 1947. For complete information, write or wire now to Francis H. Redewill, M.D., secretary, American Physicians Art Association, Flood Building, San Francisco, California, or to the sponsor, Mead Johnson & Company, Evansville 21, Ind., U. S. A.

### UROLOGY AWARD

The American Urological Association offers an annual award "not to exceed \$500" for an essay (or essays) on the result of some clinical or laboratory research in Urology. Competition shall be limited to urologists who have been

in such specific practice for not more than five years and to residents in urology in recognized hospitals.

For full particulars write the secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before May 1, 1947.

The selected essay (or essays) will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Buffalo, New York, June 30-July 3, 1947.

### NEW INFANTILE PARALYSIS FILM

The newly produced motion picture, "*A New Horizon*" filmed by RKO-Pathé for The National Foundation for Infantile Paralysis and approved by the American College of Surgeons is now available for the medical profession.

The film depicts a complete physical therapy department and shows the way in which it is utilized in the modern hospital.

The 16mm sound prints of this film can be secured on a loan basis or purchased, the price being \$21. Address The National Foundation for Infantile Paralysis, 120 Broadway, New York 5, N. Y.

### EYE-BANK AWARDS AND APPOINTMENTS

The Board of Directors of the Eye-Bank for Sight Restoration, Inc., has announced the following scholarship and fellowship awards and appointments:

Dr. Herbert M. Katzin of New York has been put in charge of the Laboratory for Ophthalmic Research of the Eye-Bank for Sight Restoration, Inc.

Dr. Frank Constantine has been granted a Fellowship to pursue studies in relation to corneal vascularization.

Dr. Arnold Forest of the Army Institute of Pathology, Washington, D. C., has been granted a Fellowship for training in Ophthalmic Pathology with special emphasis on corneal pathology.

Dr. Milo H. Fritz of New York has been granted a Fellowship to continue studies in vitreous replacement and vitreous transplants.

### Sodium Fluoride Reduces Dental Caries

A recent report from the U. S. Public Health Service in cooperation with the Minnesota Department of Health and the University of Minnesota presents data on the dental caries experience in the permanent teeth of a group of Minnesota school children treated topically with 2 per cent sodium fluoride solution. Over a period of three years it was found that the number of teeth initially attacked by caries was 36.7 per cent less in treated than in untreated teeth. It was also found that the number of additional tooth surfaces attacked in teeth which were carious at the time of treatment was 23.9 per cent less in treated than in untreated carious teeth.

## OBITUARY

**Robert Child Paine, M.D.**

**1873 - 1946**

Robert Child Paine was born in Woodstock, Connecticut, on December 12, 1873. He attended the public schools of Woodstock and Woodstock Academy. He then went to Mt. Hermon School, Mt. Hermon, Massachusetts, and from there to Dartmouth Medical School, where he was graduated with an M.D. in 1900.

He was an intern at the Boston City Hospital for one year and started the practice of medicine in 1901 in Thompson where he has practiced ever since. On November 12, 1901, Dr. Paine married Agnes Child. There were two children, Hamilton Child born on August 10, 1902, and Prudence Child born on June 5, 1905. Prudence is now Mrs. Kwiecien and lives in Shaker Heights, Ohio. Hamilton is unmarried and lives in Boston.

Dr. Paine was in charge of the Tonsil Clinic at the Day Kimball Hospital from 1921 to 1944. He was a member of the house staff of this hospital from 1901 and was president of the staff for the past ten years.

He was appointed as medical examiner soon after he started to practice and continued in this position until his death. I believe he was the oldest medical examiner in length of service in the state.

In World War I Dr. Paine served from October 1918 to September 1919 as a first lieutenant in the Medical Corps. Since then he has been a member of the American Legion.

For the past thirty years he played golf at the Quinnattisett Golf Club in Thompson and held the record low score of 32 (2 below par) for this course which has never been equalled by an amateur.

He was Councilor for the Windham County Medical Association for the past ten years.

Dr. Paine was feeling well on the last day of his life and played golf in the afternoon of November 7. He had just played a hole in par when he was taken by pain in the substernal region. An hour later he died at the Day Kimball Hospital in Putnam.

The funeral was held at the Thompson Hill Church on Sunday, November 10, 1946, and the burial was in the West Thompson cemetery. The

funeral was conducted by Rev. Orlo Barnard, minister of the Thompson Hill Church, and by Rev. Henry Robinson, minister of the Congregational Church of Putnam. Rev. Robinson was playing golf with Dr. Paine when he had his fatal coronary attack and had just scored a 4 on the hole that Dr. Paine made in par 3. The bearers at the funeral were, Drs. A. J. LaPalme, C. R. Garcin, William Mac Shepard, David Bates, Moses Margolick and Karl Phillips.

Karl T. Phillips, M.D.

## OUR NEIGHBORS

### Massachusetts

Expansion of Harvard University's School of Public Health through two important faculty appointments and the institution of two new degrees in research were recently announced by Brigadier General James S. Simmons, dean of the school. Those joining the staff are Dr. Hugh R. Leavell, formerly assistant director of the Division of Medical Sciences, Rockefeller Foundation, and Dr. John C. Snyder, former member of the United States Typhus Commission. In addition to degrees that presuppose the qualification of Doctor of Medicine, the school has added the degrees of Master of Science in Hygiene, and Doctor of Science in Hygiene, which are open to research workers. Thus the investigation of problems connected with public health, as well as instruction, will be augmented. Dr. Leavell will occupy the chair of public health practice, which became vacant in July owing to the death of Dr. Edward G. Huber. Dr. Snyder has been appointed professor of public health bacteriology, a new chair created by the reorganization of the school.

When the United States Typhus Commission was organized during the Second World War, Dr. Snyder was appointed as a member. As such he studied typhus fever at close range in the Middle East and Italy. Since his release from the Army in 1945 he has been in charge of a program of typhus investigation sponsored by the International Health Division.

### New York

Governor Dewey announced recently the designation of an inter-departmental health council to formulate and put in operation through the State



Departments the necessary implementation for the State's expanded public health program.

The Council consists of the State Commissioners of Health, Social Welfare, Mental Hygiene and Education, with Assemblyman Lee B. Mailler, chairman of the Health Preparedness Commission, as an advisory member.

The 1946 Legislature started the State on an expanded program for integration of public health services, stimulated by the extension of State aid to the localities, particularly to the cities. Legislation also was passed for an all out attack upon tuberculosis, which eventually will require an annual contribution of \$7,000,000 by the State.

New York University College of Medicine on November 13, 1946, opened to the public an exhibit on anesthesia in commemoration of the centennial of the discovery of ether. This medical school is said to have been the first to offer a postgraduate course in nerve blocking and to be the only medical school in the country where such instruction is available. Old and rare items connected with the history of anesthesia were displayed in the exhibit.

Rhode Island

The House of Delegates of the Rhode Island Medical Society at its recent meeting in September, 1946, voted to change the assessment of dues for 1947 to \$40 for Fellows of the Society in practice more than one year, and \$25 for those in their first year of practice. This action followed a recommendation from the budget committee "to provide a reserve fund to permit necessary expenditures without a special tax upon the membership, to provide an endowment fund which is sorely needed, and to retain and add to the valued staff of employees who might be attracted to positions offering higher remuneration."

Vermont

The New Hampshire-Vermont Physician Service has been approved by the Vermont Department of Banking and Insurance. This non profit service to meet the cost of surgical and medical care is the final result of the steps taken by the Vermont State Medical Society during 1946. It is in effect a consolidation of the Vermont Physician Service, Inc., organized by the Society, with the pre-existing New Hampshire Physician Service, and was made possible by legislation passed at the special session of the

Vermont Legislature this past fall. Amendments to the by-laws by which the New Hampshire Physician Service changed its name to the New Hampshire-Vermont Physician Service, also provide for adequate Vermont representation in the consolidated organization. The following Vermont physicians were designated as trustees: Leon E. Sample, St. Albans; Hiram Upton, Burlington; Woodhull S. Hall, Bennington; Allan D. Sutherland, Brattleboro; Albert M. Crane, Bridgewater; Theodore H. Harwood, Burlington; Elbridge E. Johnston, St. Johnsbury; also the following laymen: S. Aldis Miller, St. Albans; Laurence C. Campbell, Barre; Roy D. Watkins, Rutland; F. Ray Adams, Springfield; and Douglas Kitchel, St. Johnsbury. It is contemplated that the plan for doctor participation will be presented to the County Medical Societies without delay.

The Vermont State Health Council, sponsored by the Vermont State Medical Society, was formally organized by the representatives of 28 state agencies and state-wide volunteer organizations on November 15, 1946.

NEWS  
*from County Associations*

Fairfield

The regular monthly meeting of the Bridgeport Medical Association was held at the University Club on Tuesday evening, December 3. As this was the annual meeting the secretary gave his report of the year. He informed the members that there had been an increase in the attendance at the meetings during the year and that twenty-one new members had been added to the roster. The treasurer also gave a healthy report on the finances of the association.

At the meeting the nominating committee reported the new slate of officers for the coming year. The members voted in the following officers: President, Charles W. Nichols; President-Elect, Irving B. Akerson; Vice-President, Daniel Keegan; Secretary, Edwin R. Connors; Treasurer, James F. Walsh. During the business session Louis M. Oros and Frank G. Elliott, Jr., were admitted to membership. The committee on arrangements for the banquet reported that it would be held at the Stratfield Hotel on January 14, 1947.

The scientific part of the meeting consisted in two papers by local physicians. Charles B. Gaffney spoke on "A Case of Pneumonia," and Daniel B. Hardenbergh's paper was entitled "Heart Block." Both of these papers showed considerable preparation and were discussed by many of the members. The evening compared favorably with any of the year. The usual buffet followed.

The staff meeting at the Bridgeport Hospital on November 15 was addressed by Dr. Matthew Griswold who told the meeting of the work done by the State of Connecticut in cancer.

Among those present at the Yale-Harvard game in Cambridge were Drs. Booe, Truatman and Greenspun. Dr. Greenspun being airminded took the early morning plane from Bridgeport. Dr. J. Stanley Nickum is spending a short vacation in Montreal, Canada. Dr. Roger TerKuile is Florida bound, having left Bridgeport behind on December 7. Dr. John O'Connell is in Florida for an extended stay after his recent illness and is accompanied by his family. Congratulations are in order for Drs. Joe Smith and John Buckley on recent new arrivals. Dr. Charles W. Gardner, head of the Cardiology Department at Bridgeport Hospital recently flew to Chicago to visit his son Charles, a student at Chicago University. Dr. Gardner is sold on air travel and at present is making inquiries as to the longest air route to New Orleans for his next flight.

### Hartford

Harry J. Gray, M.D., Hartford, received notice under date of October 22, 1946, that he had successfully passed the examination of the American Board of Otolaryngology and had been certified by that Board.

"Political Medicine as Viewed by One of Connecticut's Psychiatrists" is the title of an article by C. Charles Burlingame of Hartford, published in *The Journal of the Indiana State Medical Association*, September, 1946.

At the Inter-American Congress on Radiology held in Havana, Cuba, in November, 1946, Henry S. Kaplan, Donald W. Seldin, and Henry Bunting, all of New Haven, presented a paper entitled "Rheumatic Pneumonia."

At the annual meeting of the Manchester Medical Association held on November 13, 1946, at the home of Douglas J. Roberts in Bolton, J. V. Prignano and Florence Marsh were admitted to membership.

Awards made at the meeting consisted of the D. C. Y. Moore Cup to E. R. Zaglio as the winner of the handicap golf match and a gold belt buckle to Howard Boyd, winner of the match play golf tournament.

The officers elected for the coming year are Howard Boyd, president; David M. Caldwell, vice-president; A. Elmer Diskan, secretary-treasurer; and D. C. Y. Moore, permanent honorary president.

At the conclusion of the meeting, a social hour and pheasant dinner was served. After that a series of films were shown. These included one taken by Dr. E. R. Zaglio during his tour of duty in the Aleutians, and those taken on several of the New Brunswick fishing trips made by members of the association.

William B. Scoville of Hartford addressed the Bristol Exchange Club on November 11, 1946, on the rehabilitation program for paraplegia patients in Connecticut which is being provided by the Hartford Hospital and the Connecticut Cancer Society. Dr. Scoville, who is working closely with the Connecticut Society on making available to paraplegics the best possible rehabilitation facilities, first became interested in this type of disability while in the armed services. At Cushing General Hospital he helped to set up a complete rehabilitation program for the 125 paraplegic cases convalescing there.

### Middlesex

Joseph C. Clifford of Gloversville, N. Y., has been appointed an assistant physician at the Connecticut State Hospital in Middletown.

After completing a year's rotating internship at the Montreal General Hospital in 1944, Dr. Clifford entered the Army and served in the neuropsychiatric section of the Mason General Hospital and the Fort Meade Station Hospital before going overseas. He served with the 1st Armored Division as neuropsychiatrist and attained the rank of major.

The new staff member attended Gloversville schools and received his A.B. degree at Union College, Schenectady, and graduated from the McGill University School of Medicine in 1943. Dr. Clifford is married and has one child.

On October 10 the Middlesex County Medical Society held its semi-annual meeting at the Edge-wood Country Club. The following new members were elected to the society: Harry S. Knight, Amrico D. Longo, Philip Berwick, Norman Freisen.



The scientific program included a paper on "Changes on the Nasal Mucosa as a Result of Psychic Stimulation" given by Dr. Stewart Wulf of New York and the "Results of the Atomic Bomb on Hiroshima" by Dr. John Larken of New Britain. The Ladies' Auxiliary joined the society members for dinner and a social evening.

Congratulations are in order to Clare B. Crampton and Vincent J. Vinci on attaining their American Board Diplomas in Obstetrics and Gynecology and Surgery, respectively. This increases our number of American Board members and is a source of encouragement and pride to their colleagues.

The Central Medical Society held its first fall meeting at Bengston-Wood Hall on November 12. A symposium on the new veterans legislation is affecting the veterans care by their private physician was conducted by representatives of the Veterans Center in Middletown, Mr. Raymond Wamester; The Connecticut Reemployment Commission, Mr. Jeremiah Fitzgerald; the Veterans Administration, Mr. James Burch; the State Medical Society, Dr. Joseph D'Esopo. The society is making plans for its centennial to be celebrated in February, 1947.

There has developed almost a constant struggle between the devotees of The Rod and Gun hobbyists and the Railroad Engineers as to the relative merits of their respective hobbies. Two of the former, being unable to find many of the elusive feathered "friends" are traveling to North Carolina to bring home the Christmas goose. The latter group find their home firesides sufficiently intriguing.

The Medical Board of the Middlesex Hospital held its annual election on November 13, with Louis O. LaBella being elevated to president, succeeding Harry S. Frank. F. Erwin Tracy was elected vice-president and Clare B. Crampton, secretary, and Richard F. Grant, representative to the Medical Advisory Council.

**New London**

Contrary to the recommendation of a special committee of the New London City Medical Society, the post of city physician is to be continued. The new incumbent is Joseph M. Wool, M.D., who served as a captain in the Army Medical Corps during the war. He succeeds Charles E. Dyer, M.D.,

who resigned recently to accept the position of school physician.

On Thursday, December 5, at Uncas-on-the-Thames the New London County Medical Association was addressed by Dr. Charles Carroll Lund, assistant professor of surgery, Harvard Medical School, on the subject, "Pre- and Post-Operative Nutrition." Those present were well rewarded by a most scientific presentation given by one well qualified to discuss the subject.

Arnaud R. La Pierre has opened his office in the Shannon Building, Norwich, for the practice of Eye, Ear, Nose and Throat. Dr. La Pierre is a graduate of College of Physicians and Surgeons, Columbia University, 1938, and did special work at the New York Eye and Ear Infirmary, New York City. He served in the armed forces, reaching the rank of Lt. Commander, U. S. Navy. Dr. La Pierre is a son of the late Dr. Leone La Pierre, well known and respected here in Norwich and greatly missed.

Nicholas T. Phillips has opened his office for the practice of medicine and surgery at 91 Main Street, Norwich. Dr. Phillips is a graduate of Boston University School of Medicine in 1944 and served in the armed forces with the rank of Lt. (j.g.) U. S. Navy.

**New Haven**

Clyde L. Deming addressed the Southern Medical Association recently at Miami, Florida, on "The Effect of Endocrine Therapy on Prostatic Cancer."

**Windham**

Walter Rowson, a former intern at the Hartford Hospital, has opened an office in Putnam for the general practice of medicine.

**News from Yale University  
School of Medicine**

Maxwell Pasternak, M.D., has been appointed assistant clinical professor of psychiatry and mental hygiene at the Yale University School of Medicine.

## THE HOSPITAL SURVEY AND CONSTRUCTION ACT

### Public Law 725 of the 79th Congress

With the signing of the Hospital Survey and Construction Act, the Nation has embarked on the most comprehensive hospital and public health construction program ever undertaken. Congress has authorized the appropriation during the next five years of \$375,000,000 in Federal funds for the building of hospitals and health centers. Since the Act provided that the Federal share is to constitute one-third of the cost and non-Federal funds the other two-thirds, the total expenditure for this Nation-wide hospital program would approximate \$1,125,000,000.

To facilitate an understanding of this Act and to show how individual hospitals, communities and States will participate with the Federal Government in this program, the following summary has been prepared, containing the most important features of the legislation. Copies of the Hospital Survey and Construction Act, Public Law 725 of the 79th Congress, may be procured at five cents per copy from the Superintendent of Documents, Government Printing Office, Washington, D. C.

#### SUMMARY OF THE HOSPITAL SURVEY AND CONSTRUCTION ACT

*Purpose:* The purpose of this Act is to provide Federal assistance to the States to the end that "the necessary physical facilities for furnishing adequate hospital, clinic, and similar services to all their people" will be attained. Federal grants-in-aid are authorized to assist the States:

1. To determine their hospital and public health center needs through Statewide surveys.
2. To develop State-wide programs for construction of facilities needed to supplement existing facilities.
3. To construct facilities which are thus determined to be necessary, and which are in conformity with the construction program constituting the approved Statewide plan.

*"Hospital" Broadly Defined:* The kinds of facilities which may be constructed under this program include:

1. Hospitals—general, tuberculosis, mental, chronic, disease, and other types except those furnishing primarily domiciliary care. These include public and other nonprofit hospitals. The latter term means any hospital owned and operated by a corporation or association no part of the net earnings of which inures, or may lawfully inure, to the benefit of any private shareholder or individual.

2. Public Health centers—which are defined to mean a publicly owned facility for the provision of public health services, the scope of which would be a matter of State law.

3. Related facilities—which, in the case of a hospital, would include laboratories, out-patient departments, nurses' homes and teaching facilities, and central service facilities operated in connection with the hospital. In the case of a public health center, related facilities would include laboratories, clinics, and administrative offices operated in connection with the center.

*"Construction" Defined:* As used in this Act, the term "construction" is also broadly defined to include:

1. Construction of new buildings.

2. Expansion, remodeling and alteration of existing buildings.

3. Initial equipment of any such new or existing buildings, including architects' fees.

Specifically excluded are the cost of off-site improvements and, except with respect to public health centers, the cost of the acquisition of land. The "cost of construction" means the amount found necessary by the Surgeon General for the construction of a project.

*Administration:* The Federal administration of this program is the responsibility of the Surgeon General of the Public Health Service in the Federal Security Agency. He has the advice and assistance of a Federal Hospital Council with which he is required to consult in administering this Act. The Council consists of the Surgeon General as chairman, and of 8 members appointed by the Federal Security Administrator. Of the 8 appointed members, 4 are persons who are outstanding in fields pertaining to hospital and health activities, and 3 of these 4 are authorities in matters relating to the operation of hospitals. The other 4 members represent the consumers of hospital services and are familiar with the need for hospital services in urban or rural areas.

The Council has the responsibility of approving the Surgeon General's general regulations governing State hospital construction plans. The Council would also be the body to which an appeal could be taken by States whose State plans are disapproved by the Surgeon General. The decision of the Council will be final in such appeals. The Council's other functions are advisory.

#### SURVEYS AND PLANNING

*Appropriation:* The Act authorizes the appropriation of \$3,000,000 in order to assist the States to survey their needs for hospitals and related facilities and to develop programs for the construction of additional hospitals, public health centers and related facilities.

*State Applications:* In order to qualify for a Federal grant for such surveying and planning purposes, a State must have an application approved by the Surgeon General. He is required to approve any application which complies with these conditions:

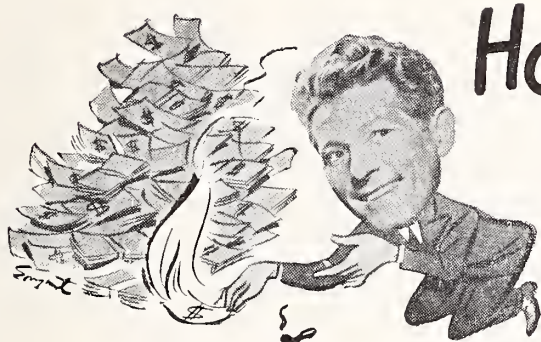
1. It must designate a single State agency to conduct the survey and planning, and make such reports as the Surgeon General may require.

2. It must provide for a State *advisory* council which must include "representatives of nongovernment groups, and of state agencies, concerned with the operation, construction, or utilization of hospitals, including representatives of the consumers of hospital services."

3. It must provide for making an inventory and survey of existing and needed hospital and related facilities and for developing a construction program.

*Allotments and Payments to States:* The funds which are appropriated by Congress for such surveys and planning





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by DANNY KAYE



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will be allotted among the States on a population basis. No State, however, may be allotted less than \$10,000. *Within their allotments the States which have approved applications will be entitled to receive 33 1/3 per cent of their expenditures in carrying out these surveys and planning functions.*

#### CONSTRUCTION OF HOSPITALS AND RELATED FACILITIES

**Appropriation:** The Act authorizes the appropriation of \$75,000,000 for each of the 5 fiscal years beginning July 1, 1946, in order to assist the States in the construction of needed public and other nonprofit hospitals, public health centers, and related facilities.

**General Regulations:** Within 6 months after approval of the Act, the Surgeon General—with the approval of the Federal Hospital Council and the Federal Security Administrator—must promulgate general regulations on specified matters referred to below. The regulations are largely concerned with the number and general method of distribution of hospitals to be constructed under the program.

1. In the case of general hospitals, the distribution is intended to recognize base areas, intermediate areas, and rural areas. An over-all limitation, for purposes of this program, would be 4 1/2 beds per 1,000 population, except that higher figures (up to 5 1/2 beds per 1,000 population) would be permitted in sparsely populated States.

2. The maximum ratio of beds for other types of hospitals would be as follows:

a. Tuberculosis—2 1/2 times the annual average deaths from tuberculosis.

b. Mental—5 beds per 1,000 population.

c. Chronic disease—2 beds per 1,000 population.

3. The limitation on public health centers would be 1 per 30,000 population. However, in States having less than 12 persons per square mile, it shall not exceed 1 per 20,000.

4. Regulations are authorized prescribing the manner in which the State agency must decide the priority of projects based on the relative need of different sections of the population and of different areas lacking adequate facilities, with special consideration to be given hospitals serving rural communities and areas with relatively small financial resources.

5. Regulations are also authorized covering general standards of construction and equipment.

6. The regulations would require that the State plan provide for adequate hospital facilities without discrimination on account of race, creed, or color, and for adequate facilities for persons unable to pay. Such regulations may require that an applicant for an individual project give assurance that it will serve all persons residing in the territorial area of the applicant. The latter requirement, however, must permit of an exception where separate hospital facilities are provided for separate population groups, but only if the State plan makes equitable provision, on the basis of need, for facilities and services of like quality for each group. The regulations may also require that an applicant give assurance to the State that it will furnish a reasonable volume of hospital services to persons unable to pay, unless the hospital is financially unable to undertake such a commitment.

7. Finally, provision is made for regulations prescribing the general methods of administration of the State plan. This authorization relates solely to the administration of the construction plan by the State agency, and does not in any way relate to the administration of hospitals.

**State Plans:** In order to obtain Federal funds for the construction of hospitals under this bill, a State is required to formulate and have approved by the Surgeon General a State plan. Such State plan must:

1. Designate a single State agency to administer or supervise the administration of the plan.

2. Demonstrate that the State agency so designated will have the necessary authority to carry out the plan.

3. Provide for a State advisory council to consult with the State agency in carrying out the plan.

4. Set forth a hospital construction program based on a Statewide inventory of existing hospitals and survey of need which conforms to the regulations promulgated by the Surgeon General.

5. Set forth the relative need for the individual projects included in the plan, and provide for their construction (insofar as financial resources available for construction and for maintenance and operation permit) in the order of the relative need determined in accordance with regulations prescribed by the Surgeon General.

6. Provide such methods of administration of the State plan, including establishment and maintenance of personnel standards on a merit basis, as the Surgeon General by regulation requires, except that he may exercise no authority with respect to the selection, tenure of office, or compensation of persons employed by the State agency.

7. Provide minimum standards for the maintenance and operation of hospitals which receive Federal aid under this plan. This would be a matter entirely for determination by the respective States. Each State must, prior to July 1, 1948, enact legislation establishing minimum standards for the maintenance and operation of hospitals which shall have received aid under this Act. Any State failing to enact such legislation will be deprived of further allotments under the bill.

8. Provide for affording to applicants for a construction project an opportunity for hearing before the State agency.

9. Submit reports and information required by the Surgeon General.

10. Provide for the review by the State agency of the construction program contained in the plan and submit modification which it considers necessary to the Surgeon General.

The Surgeon General is required to approve any State plan which complies with the above conditions. In any case in which the Surgeon General disapproves a plan, the Federal Hospital Council must afford the State agency an opportunity for hearing. If the Council determines that the State plan complies with such requirements, the Surgeon General must approve the plan.

**Project Applications:** For each project for construction pursuant to an approved State plan, an application must be submitted to the Surgeon General through the State



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agency. Such application may be made by the State or a political subdivision thereof, or by a public or other non-profit agency. Such application must set forth:

- 1. A description of the site and reasonable assurance as to its title.
- 2. Plans and specifications complying with Federal regulations.
- 3. Reasonable assurance of adequate financial support both for construction and for *maintenance and operation of the hospital when completed*.
- 4. Reasonable assurance of the payment of prevailing wages for construction work.

*Approval of Projects:* The Surgeon General would be required to approve any application which contains the required information and assurances as to title, financial support, and payment of prevailing rates of wages, provided that:

- 1. Funds to pay 33 1/3 per cent of the cost are available from the Federal allotment to the State.
- 2. The application conforms to the approved State plan and gives assurance of compliance with requirements of the plan and regulations concerning the availability of hospital services without discrimination on account of race, creed, or color, and for persons unable to pay, as well as assurance of compliance with State standards for operation and maintenance.
- 3. The application has been approved and recommended by the State agency and is entitled to priority in accordance with Federal regulations.

No application may be disapproved until the Surgeon General has afforded the State agency an opportunity for a hearing.

*Allotments:* Federal funds for construction would be allotted on the basis of a formula based on the factors of population and per capita income of the States. Under this formula the States with the lower per capita incomes are allotted a higher amount of funds per capita.

*Payments:* Federal funds shall constitute 33 1/3 per cent of construction costs. Federal payments would be made to the State agency for transmission to the applicant. However, if the State agency is legally unable to make payments to any particular applicant, payment would be made by the Federal Government directly to the applicant.

WITHHOLDING OF FEDERAL FUNDS

Hearings: After notice and opportunity for hearings, the Surgeon General may withhold Federal payments if he finds:

- 1. A State agency is not complying substantially with the required provisions of an application for survey funds or of the State plan for the construction of hospitals.
- 2. Funds have been diverted from the purposes for which they were allotted or paid.
- 3. Any assurance given in an application for a construction project is not being or cannot be carried out.
- 4. There is a substantial failure to comply with approved plans and specifications for construction projects.

The withholding may be of all funds otherwise payable to the State or on account of projects within the State, or it may be limited to a particular project or projects, depending upon the nature of the default. The Surgeon General's action in both withholding funds or refusing to approve an application for construction funds would be subject to an appeal to the United States Circuit Court of Appeals.

ALLOTMENT FIGURES, HOSPITAL SURVEY AND CONSTRUCTION ACT\*

STATE	ALLOTMENTS	
	SURVEY AND PLANNING \$3,000,000	CONSTRUCTION \$75,000,000
Alabama .....	\$ 62,422	\$ 2,888,925
Alaska .....	10,000	40,200
Arizona .....	13,482	452,175
Arkansas .....	39,294	1,968,300
California .....	185,820	1,957,875
Colorado .....	24,279	657,300
Connecticut .....	40,474	421,950
Delaware .....	10,000	86,625
District of Columbia .....	19,145	298,350
Florida .....	47,141	1,461,900
Georgia .....	68,735	2,978,775
Hawaii .....	10,119	237,525
Idaho .....	10,531	293,550
Illinois .....	172,752	2,771,175
Indiana .....	77,526	1,727,775
Iowa .....	51,182	1,341,675
Kansas .....	37,908	933,750
Kentucky .....	57,672	2,589,600
Louisiana .....	53,631	2,156,850
Maine .....	17,671	454,875
Maryland .....	46,167	870,675
Massachusetts .....	93,515	1,595,550
Michigan .....	124,372	2,172,000
Minnesota .....	56,876	1,655,700
Mississippi .....	45,548	2,403,825
Missouri .....	79,679	2,282,550
Montana .....	10,355	231,825
Nebraska .....	26,461	685,200
Nevada .....	10,000	49,575
New Hampshire .....	10,207	342,375
New Jersey .....	93,928	1,313,775
New Mexico .....	11,210	457,500
New York .....	282,492	2,945,100
North Carolina .....	76,287	3,432,825
North Dakota .....	11,889	308,475
Ohio .....	156,144	2,692,575
Oklahoma .....	44,427	1,640,550
Oregon .....	27,317	460,875
Pennsylvania .....	209,243	4,551,675
Puerto Rico .....	46,049	2,430,525
Rhode Island .....	15,989	280,275
South Carolina .....	41,123	1,976,775
South Dakota .....	12,066	359,625
Tennessee .....	64,812	2,673,300
Texas .....	145,051	4,842,075
Utah .....	13,541	365,100
Vermont .....	10,000	214,725
Virginia .....	64,310	2,210,175
Washington .....	44,722	512,100
West Virginia .....	39,294	1,555,650
Wisconsin .....	67,142	1,622,925
Wyoming .....	10,000	144,975
	\$3,000,000	\$75,000,000

\*Figures are contingent upon Department of Commerce certification of population data.





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## NEW BOOKS IN REVIEW

*THE 1946 YEAR BOOK OF RADIOLOGY—July, 1945—June, 1946.* *DIAGNOSIS* edited by Charles A. Waters, M.D., Assistant Professor of Roentgenology, Johns Hopkins University School of Medicine; Associate Editor, *Whitmer B. Firor*, M.D., Instructor in Roentgenology, Johns Hopkins University School of Medicine. *THERAPEUTICS* edited by *Ira I. Kaplan*, M.D., Director, Radiation Therapy Department, Bellevue Hospital, New York City, Clinical Professor of Surgery, New York University Medical College. Associate Editor, *Sidney Rubinfeld*, M.D., Visiting Radiation Therapist, Bellevue Hospital. *Chicago, Illinois: The Year Book Publishers, Inc.* 1946. 463 pp. with illustrations. \$5.50.

Reviewed by WENDELL C. HALL

The 1946 Year Book of Radiology, as in previous years, is divided almost equally between diagnostic x-ray and irradiation therapy, with a total review of more than 350 articles. The articles are well illustrated with an average of more than one illustration for each article in the diagnostic section in addition to numerous illustrations in the therapeutic section. As to be expected, there has been an increase in the number of articles abstracted from European and South American literature since the end of the war; in fact, approximately one third the diagnostic section and one half the therapeutic section are comprised of articles obtained from sources outside the United States. Under the editorship of Dr. Waters and Dr. Kaplan the usual high standards of The Year Book have been maintained this year.

*DIABETES—A CONCISE PRESENTATION.* By *Henry J. John*, M.A., M.D., F.A.C.P., Lt. Col., M.C., Cleveland, Ohio. *St Louis: The C. V. Mosby Company.* 1946. 300 pp. Illustrated. \$3.25.

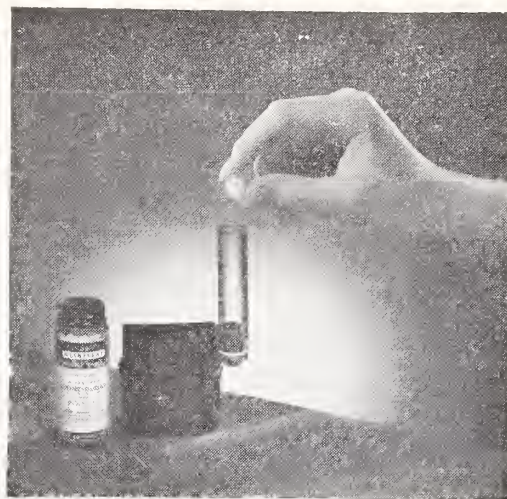
Reviewed by WILLIAM E. HALL

This is a very readable instructive book. The author goes into all phases of the diabetic state exhaustively—its cause, differential diagnosis and treatment. The importance of the glucose tolerance test and the pitfalls which must be avoided in its interpretation are stressed and thoroughly illustrated by many case reports and illustrations.

Dr. John gets right down to cases and clearly outlines the steps to be taken in treating diabetes in all of its various forms. His instructions are concise and understandable and cover all phases from instructing the mother of a child in preparing his diet to the treatment of emergencies, such as diabetic coma and the preparation of the severe diabetic for surgery.

The relationship between glycosuria and hyperglycemia and that between insulin therapy and the insulinogenic function of the pancreas are discussed. Arguments pro and con regarding the various theories concerning diabetes, obesity, hyperthyroidism, and various other endocrine glandular dysfunctions are presented in detail.

The section on diets is complete and the instructions to be given to the patient put forth in such a manner that he will



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**HYGIENE.** (Fourth Edition.) A textbook for college students on physical and mental health from personal and public aspects by *Florence L. Meredith, B.Sc., M.D.*, Fellow of the American Medical, American Public Health, and American Psychiatric Associations; Professor of Hygiene and Public Health, Tufts College. *Philadelphia: The Blakiston Company.* 1946. 838 pp. with 155 illustrations. \$4.00.

Reviewed by JOSEPH I. LINDE

Written for college students as a text book on healthful living, the book is divided into nine parts, a supplement and a bibliography. The subject is well covered and the approach is clear.

As an introduction, the health situation in the United States is presented by means of essential vital statistical material and discussion of basic health information. Anatomy and physiology is then given in a simple, understandable manner. Disease and recovery is discussed in the next sections. Included under the caption of "Forces for Health" are sections on the History of Medicine, Using Medical Services, Avoiding Cults and Quackery (these latter two particularly interesting and informative to the lay person), Public Health,

Personal and Preventive Medicine. Infections, cardio-renal-vascular diseases, diabetes, and other major health problems, as well as accidents and poisonings, self medication, alcoholic and habit-forming drugs are next presented. The broad subject of the Hygiene of Everyday Life is discussed at great length under many headings. A part on Reproduction and part IX on Mental Hygiene conclude the volume. The material on mental hygiene is well assembled and is written in an understanding manner.

An excellent bibliography is appended. The volume is lengthy, but complete, and meets the purpose for which it was intended.

**THE CENTENNIAL OF SURGICAL ANESTHESIA.**

*Compiled by John F. Fulton, M.D., and Madeline E. Stanton, A.B.* An Annotated Catalogue of Books and Pamphlets Bearing on the Early History of Surgical Anesthesia. Exhibited at the Yale Medical Library October 1946. *New York: Henry Schuman.* 1946. 102 pp. \$1.00.

Reviewed by STANLEY B. WELD

The Yale University School of Medicine commemorated two milestones in medical history with two exhibits, outstanding for their excellence. One was displayed in December 1944 in memory of Horace Wells' first use of nitrous oxide for a tooth extraction; the other appeared in October 1946 as a centennial exhibit on the early history of surgical anesthesia. The Yale collection of the early writings on anesthesia

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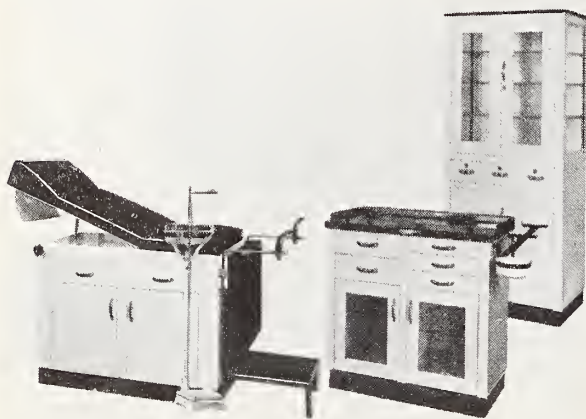
\* Bureau of Health Education, A.M.A. Hygeia, 24:352, May, 1946.



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has grown steadily and today, as Dr. Fulton points out, is exceptionally full but not complete.

This volume consists of a list of the tracts on anesthesia in this collection, interestingly annotated, and classified under twelve headings. The section on Regional and Block Anesthesia and the one on Studies on Individual Anesthetics have been omitted because incomplete.

To the physician or student who may be interested in the controversial subject of the discoverer of surgical anesthesia, this volume will serve as a valuable guide. And who is there in the profession who could have lived in the shadow of the Massachusetts General Hospital or traversed the shaded streets of Connecticut's capital city who can fail to find frequent enough touches of local color to arouse his interest in those immortals of anesthesia—Crawford Long, Horace Wells, William T. G. Morton, Charles Jackson and James Y. Simpson?

*W. T. G. MORTON'S MEMOIR ON SULPHURIC ETHER*—1847 with a Foreword by John F. Fulton. *New York: Henry Schuman.* 1946. 24 pp. \$1.50.

Reviewed by STANLEY B. WELD

The publisher has performed a valuable service in reprinting W. T. G. Morton's Memoir to the Academy of Sciences at Paris in defense of his claim to the discovery of ether as a surgical anesthetic. Dr. Fulton in his foreword calls the reader's attention to the importance of this celebrated letter of Morton's and to the timeliness of its reprinting on the occasion of the ether centennial.

It is a clear statement of facts, written by a young man who believes in himself and therefore can face the world no matter what the outcome. Students of medical history will welcome this reprint.

*PSYCHIATRY TODAY AND TOMORROW.* By S. Z. Orgel, M.D., F.A.P.A., Consulting Psychiatrist, Miriam Barnert Memorial Hospital, Paterson, N. J., Attending Psychiatrist, Hillside Hospital, Bellerose, L. I., New York. *New York: Interantional Universities Press.* 1946. 514 pp. \$6.00.

Reviewed by PHILIP J. MOORAD

Dr. Orgel's twenty-five years of teaching and lecturing background is evident in his didactic style. The book is interesting because of clear presentation and fluent reading. The material is arranged along the lines of a textbook, with discussion of psychiatric disorders as to cause, manifestations, course, treatment, and prognosis. The case material is presented in an illustrative manner but not in sufficient detail or variety. The section on Mental Deficiencies is not on par with the rest of the book. Certain subjects, particularly the schizophrenias, are not dealt with adequately and thoroughly as the magnitude of the subject warrants. Since the author started in practice as a pediatrician and then changed to psychiatry of psychoanalytical concept, he has emphasized psychoanalysis as a therapeutic measure in all mental illnesses, mentioning only briefly medical treatments of the same conditions. The nursing care of the psychiatric cases, whether in a hospital or at home, is handled particularly well, especially in contrast to other books of this type. An historical account of the development of psychiatry at the beginning of the book, and a review of development of our ideas upon each mental disease, from ancient time to the present, at the beginning of each chapter, is a fine and commendable feature of this book. With this in mind, and the fact that there is little said about the future of psychiatry, a more appropriate title for the book would be "Psychiatry, Past and Present." The section on Induction, War, and Rehabilitation (War Neuroses) is excellent.

Notwithstanding the fact that to the uninitiate the psychoanalytical concept and mental mechanisms are rather complex, this book is highly recommended to students, general practitioners, nurses, social workers, and laypeople who occasionally or routinely deal with mental problems. To the groups outside the profession it is a good reference book on psychiatric problems.





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## RECENT ADVANCES IN THE MEDICAL AND SURGICAL MANAGEMENT OF HYPERTENSION

WILLIAM GOLDRING, M.D., *New York*

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### MEDICAL

ATTEMPTS have been made to treat hypertensive disease with agents aimed solely at depressing the level of the blood pressure. These methods of treatment neglect the essential fact that elevated blood pressure is merely a manifestation of a fundamental fault which continues to operate, despite artificial lowering of the blood pressure. Symptomatic treatment directed solely toward lowering of the blood pressure therefore, is an unsatisfactory approach to the therapeutic problem involved in hypertensive disease. Hypotensive agents, like the nitrites, are evanescent in their effect; the effect of phlebotomy is not only evanescent, but undesirable as an unphysiological procedure. The value of transient lowering of blood pressure by these and other means is based on the assumption that excessively high levels of diastolic pressure increase the immediate likelihood of cerebral or retinal vascular accident. All available clinical and pathological evidence indicates that vascular accidents are dependent upon organic vascular disease, and may occur independently of the level of blood pressure.

### THIOCYANATE

Thiocyanate serves as an example of the ineffectiveness of those therapeutic agents aimed solely at the reduction of blood pressure. Dr. Chasis and I made a series of 74 observations on 50 hypertensive patients. In 31 per cent of the observations, thio-

cyanate lowered the blood pressure significantly, while in 17 per cent, toxic manifestations occurred. Almost invariably, a fall in the blood pressure was accompanied by subjective improvement. However, subjective improvement occurred in patients on thiocyanate therapy in whom no lowering of blood pressure occurred, suggesting that such improvement was largely psychic. It appears that thiocyanate may occasionally act as an effective depressor agent, but there is no constant dosage at which either a toxic or a therapeutic effect can be anticipated.

Recent revival of interest in thiocyanate therapy in hypertensive patients has been occasioned by the belief that repeated estimations of blood thiocyanate concentration would serve to prevent overdosage, that is, if the blood concentration is maintained between 6 and 12 mg. per cent, it is said that toxic effects are not likely to occur. We attempted to control dosage by determining the residual drug in the body each day, by subtracting the amount excreted in the urine from the amount administered. The determination of residual drug is more satisfactory than blood concentration, since it is a measure of the amount of thiocyanate retained in all body tissues and not only in the circulating blood.

There can be little doubt from our data that toxic effects, and even a fatal outcome may occur in some patients who have in their tissues a smaller amount of thiocyanate than do those who do not show toxic manifestations. It appears further that in some individuals there is no margin of safety between the toxic and so-called therapeutically effective dose of thiocyanate. The usual order in which toxic manifestations make their appearance is: muscular fatigue accompanied or followed by nausea, vomiting, dis-

*Presented at the twenty-first Connecticut Clinical Congress, New Haven, September 10, 1946*

orientation and mental confusion, motor aphasia, hallucinations of sight and hearing, and in fatal cases, progression to delirium and coma.

We have concluded from our study that there is no justification for the use of thiocyanate in hypertensive patients for the purpose of lowering blood pressure, because in common with other depressor drugs and measures, it affects a temporary lowering of blood pressure without regard to the cause of the hypertension, a result of doubtful value to the patient. The most important objection to its use is the high incidence of serious intoxication, even when the drug is used cautiously.

#### TREATMENT BASED ON THE ASSUMPTION THAT ESSENTIAL HYPERTENSION IS RENAL IN ORIGIN

It is well known that a temporary fall of blood pressure accompanies the pyrogenic reaction, either during the course of a febrile infectious disease, or when fever is induced artificially by parenteral administration of a foreign protein. This is particularly true in hypertensive patients and is followed by a prolonged increase in renal blood flow. On the theory that renal ischemia is the primary causal factor in the genesis of human hypertension, it would be supposed that repeated induction of renal hyperemia by means of the pyrogenic reaction might have a favorable effect on the hypertensive process. With the intent of examining this point, Drs. Chasis, Smith and I administered pyrogenic agents repeatedly to several hypertensive patients. A sustained reduction in blood pressure occurred, but the type of blood pressure response led us to the conclusion that the hypotensive action of pyrogenic agents does not represent a fundamental correction of the hypertensive process. It was found that during the low blood pressure phase following this reaction, the cardiac output was increased, but the peripheral resistance was markedly decreased, the net result accounting for the fall in blood pressure. On this basis, it is understandable that during this period, assumption of the upright posture may so diminish venous return to the heart as to precipitate syncope.

In the course of parenteral administration of foreign protein, sudden and alarming peripheral circulatory failure occasionally occurs. This reaction warrants emphasis, because of the inherent danger to the patient receiving parenteral foreign protein. Page and his associates have reported similar episodes in hypertensive patients treated with kidney extract. They ascribe this reaction to impurities which

occasionally contaminate some lots of the extract. We have concluded from our observations that the fall in blood pressure during a pyrogenic reaction is attributable to adverse and therefore undesirable effects upon cardiovascular dynamics. These observations on the pyrogenic reaction were designed to throw some light on the mechanism involved in the reduction of blood pressure with kidney extracts.

#### KIDNEY EXTRACT

In an experimental animal in which hypertension has been produced by interference with the blood supply to one kidney, if the opposite normal kidney is removed the blood pressure rises to higher levels and remains so indefinitely, suggesting that the normal kidney elaborates a substance capable of inhibiting or destroying a renal pressor substance. This observation has led to attempts to isolate the inhibitor substance from normal renal tissue. It has been shown that intramuscular injection of this inhibitor substance produces a significant lowering of the blood pressure in the experimental animal. Similar encouraging results have been reported in man.

However, in view of the hypotensive effect of parenterally administered foreign protein, the specific effect of such renal inhibitor substance must be questioned. In order to avoid this complicating non specific effect, Grollman, Harrison and William administered kidney extract by mouth. They observed no effect on blood pressure in hypertensive patients. With the same point in mind, we administered a kidney extract orally to 4 hypertensive patients, and in none was there any reduction of blood pressure, even though the amount administered per day was equivalent to 50 kilograms of original kidney.

It is of some importance to note that orally administered renal extracts, while ineffective in man, significantly reduce blood pressure in the animal with experimental renal hypertension. This circumstance is further corroboration of the fundamental difference between human and experimental hypertension. Since the weight of evidence is against identity of mechanism in these two types of hypertension, it might be expected that they would not be reduced by the same antipressor agent. Treatment of human hypertension with renal extracts so far, has been unsuccessful and in view of the failure to demonstrate a specific action, their use must be regarded for the present as empirical.



## TYROSINASE

Another approach to the treatment of hypertension has its origin in the observation that while carboxylation of amino acids may occur anaerobically, deamination of amines requires the presence of oxygen. In the absence of adequate oxygen in the kidneys, therefore, failure of deamination would prevent amines from entering the systemic circulation. Since many amines are known to be pressor, hypertension might be expected to result from inadequate oxygen supply to the kidneys. There is experimental support for this hypothesis. However, attempts to lower blood pressure in hypertensive man with this hypothesis in mind, have failed. Schroeder and Adams demonstrated that tyrosinase, a phenolic oxidase obtained from mushrooms, when administered to hypertensive rats and dogs, was effective in reducing their blood pressures. On the basis of this observation, we administered tyrosinase subcutaneously to 3 hypertensive patients. The results of this observation indicate that tyrosinase reduces blood pressure temporarily only as a consequence of its non-specific pyrogenic action.

Prinzmetal and his associates showed that considerable fall in blood pressure occurs after the administration of heat-inactivated tyrosinase thereby reducing the fall in blood pressure to a non-specific pyrogenic effect. These observations, strongly suggest that tyrosinase is without specific effect in human hypertensive disease.

## QUINONES

It is known that certain pressor amines can be activated by quinone precursors. The administration of certain quinones has been followed by significant lowering of the blood pressure in the hypertensive animal. However, their administration to humans has so far been unsuccessful.

## METHYLENE BLUE

It has been demonstrated that if kidney tissue is incubated with amino acids in the absence of oxygen, but in the presence of methylene blue, deamination of amino acids, formation of ammonia and reduction of the methylene blue occur. This observation suggested the possible value of methylene blue in the treatment of hypertension. On the assumption mentioned previously, that is, that hypertension in man might result from failure of the kidneys to complete deamination because of oxygen lack, we have administered methylene blue in large

amounts to hypertensive patients, without effect on the blood pressure.

## VITAMIN A

Vitamin A, administered orally, increases renal blood flow, filtration rate and maximal tubular excretory capacity in hypertensive man. On the basis of these observations, and with the previously stated hypothesis in mind, Vitamin A has been administered to hypertensive patients. Taylor and his associates, and we, have found Vitamin A to be ineffective in the treatment of human essential hypertension, when administered orally in amounts up to 400,000 international units a day for 3 months. Grollman and Harrison and Wakerlin have reduced blood pressure significantly in hypertensive animals with Vitamin A. However, they obtained the same effect with inactivated Vitamin A preparations. They concluded from this observation that the hypotensive effect of these substances is dependent not upon their Vitamin A content, but upon a substance as yet unidentified, which is present in certain fish oils. This problem is still under investigation.

The role of a metabolic fault in the kidneys concerned with failure of deamination, in the genesis of human hypertension, has not been fully explored. However, therapeutic attempts in man based on this hypothesis have so far failed.

This statement applies as well to the recently suggested rice diet, the rationale of which is based upon the assumption that hypertension results from a metabolic fault in the kidneys. The original observations have not been confirmed and there is no reason to believe from the available data that the rice diet offers any hope in the treatment of hypertensive disease.

## SURGICAL

We come now to a phase of the surgical treatment of essential hypertension which is presumably based upon knowledge of the causative mechanism. This phase of therapy was evolved in large part from observations on experimental hypertension in the animal. In 1934 Goldblatt and his associates demonstrated for the first time that persistent elevation of systolic and diastolic blood pressures can be produced in the animal by partial constriction of both main renal arteries. Since this observation there have been many advocates of the thesis that human essential hypertension is on this same basis, namely altered renal hemodynamics.

UNILATERAL NEPHRECTOMY

The role of the kidney in the pathogenesis of hypertension and therefore the specificity of unilateral nephrectomy in its cure has been fully established for experimental renal hypertension in the animal. Whether or not this relationship obtains in man is still open to question.

A few highly enthusiastic reports suggest that occasionally a unilateral destructive renal lesion such as congenital aplasia or atrophic pyelonephritis may initiate hypertension and that unilateral nephrectomy may affect a cure. On this premise, one would anticipate a higher than expected incidence of hypertension in patients with unilateral renal disease. That this is not so is evident from the following data. Table I.

TABLE I  
INCIDENCE OF HYPERTENSION IN UNILATERAL RENAL DISEASE AS REPORTED BY VARIOUS AUTHORS

	PERCENTAGE WITH HYPERTENSION
1. Friedman, Moschkowitz, and Marrus 193 patients with unilateral renal disease proven at operation.....	21.8
1,006 living controls with no demonstrable renal disease .....	22.8
2. Oppenheimer, Klemperer, and Moschkowitz 79 patients with unilateral renal disease demonstrated at necropsy.....	27.5
333 control necropsies.....	24.0
3. Baggenstoss and Barker 97 patients with unilateral renal disease demonstrated at necropsy.....	29.3
100 control necropsies.....	29.0
4. Braash, Walters, and Hammer 1,684 living patients with surgical uropathology	18.7
975 living controls.....	20.0
5. Crabtree and Chaset 150 nephrectomies for unilateral renal disease	9.0
6. Shure 66 patients with unilateral renal disease demonstrated at necropsy.....	33.3
947 living controls.....	35.1
SUMMARY	
585 patients with unilateral renal disease (items 1, 2, 3, 5, and 6).....	24.2
2,928 living controls (items 1, 4 and 6).....	26.0
433 necropsy controls (items 2 and 3).....	26.5

Dr. Chasis, Dr. Smith and I have reviewed, in detail, case reports in the literature in which unilateral nephrectomy was performed for the cure of hypertension, or where renal pathology in a hyper-

tensive patient was considered indication for nephrectomy. Seventy-six such case reports have appeared in the literature to recent date. We regarded as acceptable demonstration of the beneficial effect of nephrectomy in hypertension, those patients in whom hypertension was established by adequate preoperative control and whose blood pressure fell to normal soon after nephrectomy and persisted in the normal range for at least one year. Of the 7 recorded cases, only 7 fulfilled these criteria. However this small apparently successful group is no final proof that unilateral nephrectomy may cure hypertension because the level of blood pressure is subject to spontaneous change and also may subside for long periods of time as a result of the nonspecific effects of any surgical procedure.

The available evidence throws considerable doubt on the concept of unilateral renal ischemic hypertension in man and consequently on the rationale of nephrectomy for its cure.

Before closing this phase of the subject let me say that we believe it clearly demonstrated that partial obstruction of one or both main renal arteries is capable of producing hypertension in man as in the experimental animal. This is well demonstrated by the published case of Leadbetter and Burkland. Their patient was cured during a 3-year follow-up period after removal of a kidney whose main renal artery was partly obstructed by a congenital muscular tumor. This renal lesion is unique. In our opinion it is not analagous to the far more common unilateral intrinsic renal diseases in which we believe the renal disease and hypertension are not related.

RENAL-OMENTOPEXY AND NEPHROPEXY

In accordance with the assumption that hypertension in man is initiated by renal ischemia, two other operative procedures have been suggested and tried. Renal-omentopexy to supply a new source of blood to the kidneys and nephropexy to correct interference with renal blood flow presumably due to ptosis of the kidney with kinking of the ureter.

Unilateral renal-omentopexy was performed on two patients. The functional measurements made by us at intervals up to 18 months after operation indicated that blood flow to the operated kidney, was actually decreased by a surgical procedure designed to do the opposite.

In another patient with marked nephroptosis nephropexy was performed. Again the measurements made 12 months post-operatively showed



minution of blood flow in the operated kidney. In neither of these patients was the blood pressure lowered.

#### SYMPATHECTOMY

The treatment of human essential hypertension by sympathectomy began in 1923. Danielopolou employed a limited resection of the splanchnic sympathetic chain in two patients. They had far advanced vascular disease and the results were unsatisfactory. In 1925 Adson introduced the operation in this country. The procedure underwent a series of modifications until 1940 when Smithwick introduced the technic now in common use. He employs a trans-diaphragmatic approach and removes the sympathetic chain and its ganglia from about the 4th dorsal to the 1st lumbar on one side and to the 2nd lumbar ganglion on the opposite side, together with avulsion of all splanchnic nerves on both sides.

The rationale of this operation is inherent in the belief that reduction in size of the arteriolar bed is, at its inception, an expression of functional vasoconstriction and that hypertension is a result of the increased peripheral resistance produced in this manner. This view is widely accepted and it is logical to expect that interruption of vasoconstrictor fibers to the large splanchnic vascular bed would be accompanied by a fall in the systemic blood pressure. This thesis of course does not assume that vasoconstriction is the initial event and does imply that some other as yet unknown stimulus precedes vasoconstriction. In this sense sympathectomy cannot be expected to eliminate the cause of hypertension, but is merely intended to interrupt the pathway through which vasoconstriction is mediated to one large area of the systemic vascular tree. Sympathectomy therefore, at best, is no more than a symptomatic procedure directed solely at the level of the blood pressure. Earlier hopes that the induced vasodilation might reverse renal ischemia and thereby eliminate a presumed source of specific pressor substance has not been borne out by actual measurement of renal blood flow before and after operation. Five of our patients operated on by Dr. Wertheim at Bellevue with this point in mind, failed to show an increase in their renal blood flow.

This finding has been confirmed by others and indicates that the operation cannot be considered specific in this sense.

There can be little doubt that sympathectomy can reduce the level of blood pressure. It cannot be

denied that reduction of blood pressure to the normal range for a considerable period of time is highly desirable, yet from personal experience and the reports of others, this degree of reduction is quite exceptional and when it does occur it is most often transient. These few individuals are usually in the early stage of the disease, they show no evidence of vascular disease, their blood pressure level is highly labile and with few exceptions they fall into the normal range on bedrest alone. It is a great temptation to ascribe the results in these patients to the operation but the highly variable course of the blood pressure level in these individuals makes such a conclusion hazardous. Whether or not the operation is in fact beneficial in this group will take more data and a longer period of observation than is now available.

In the remaining larger group of patients a satisfactory operative result has come to mean a reduction in blood pressure from its preoperative level. Such reduction is called significant if the diastolic pressure falls 20 mm. Hg. or more even though the postoperative level is still in the range of hypertension. This interpretation is open to serious question and since the great majority of patients fall into this category the validity of this interpretation must determine the clinical usefulness of sympathectomy.

There are two prime objectives in the treatment of hypertension. One is specific and aimed at elimination of the cause of the disease; the other is non specific and aimed at the alleviation of symptoms.

It seems quite clear now that sympathectomy must be considered a non specific method of treatment.

Whether or not one is impressed with the results to date depends upon his acceptance of partial or temporary reduction in blood pressure as an advantage to the patient. This implies that the blood pressure itself imposes a strain on the arterioles and on the left heart. The question of the relationship between hypertension and arteriolar disease is still unanswered. There are some who believe that renal arteriolar disease precedes and accounts for the elevation of blood pressure; others advance evidence which appears to indicate that hypertension precedes and accounts for the secondary occurrence of arteriolar disease. And still a third group of investigators are of the opinion that elevated blood pressure and arteriolar disease are independent of each other, i.e. both vasoconstriction and its symptom, hypertension on the one hand, and arteriolar

disease on the other, may be unrelated, concomitant effects of the still unknown pressor mechanism. In this latter view, simple lowering of the blood pressure would not be expected to reduce the degree or extent of arteriolar disease.

The existence of these three hypotheses indicating a fundamental difference of opinion strongly suggests that any assumed advantage to the arterioles of lowered blood pressure must still be considered a matter of speculation.

It should be remembered that blood pressure is a highly variable function, the method for its measurement is crude, and in particular there is often no direct relationship between the height of the blood pressure and the severity of the disease. It would be unfortunate if a final estimate of the worth of surgery in hypertension should eventually rest on nothing more secure or significant than measurement of the level of blood pressure.

It must be accepted however that it is by far the most effective treatment in use for relief of subjective symptoms. This applies in particular to intractable and incapacitating headache. The mechanism of relief of this and other symptoms is entirely unknown since such relief frequently occurs even when the level of blood pressure is unchanged and when there is no reason to believe that the course of the disease had in any way been altered.

Uncertainty concerning the clinical value of sympathectomy is no better exemplified than in the conflicting views expressed by different investigators; one current opinion is that the operation should be restricted to those with advanced vascular disease since no other form of therapy is effective, the other is that the operation should be reserved only for the earlier stages of the disease since no benefit can be expected after extensive vascular disease has appeared. While it appears that the latter view is by far the more reasonable, we are impressed with the lack of agreement among competent observers who have had actual clinical contact with both medically and surgically treated hypertensive patients. The inference must be that the results in surgically treated patients are open to various shades of interpretation.

Its final appraisal must rest upon one single crucial criterion, namely the life span of surgically treated patients as compared with expected longevity without operation. This is admittedly a difficult and perhaps even impossible task. In its present state sympathectomy should be considered no more than a highly desirable clinical experiment.

#### SYMPTOMATIC MANAGEMENT

Finally we come to the discussion of those measures which have been found useful in the practical management of hypertensive disease.

It appears from the foregoing discussion that medical and surgical attempts at so-called specific treatment for hypertensive disease have proved disappointing. It remains, then, to plan a regime for the hypertensive patient intended to minimize the effects of the disease and prolong his period of comfort and productivity. The ultimate goal of symptomatic measures is the relief of subjective symptoms and while this is frequently accompanied by lowering of the blood pressure level, the latter is of secondary importance. Decline of the blood pressure level is not to be interpreted as regression in the underlying cause of the disease, but rather amelioration of those secondary and reversible factors which are known to be superimposed on the basic causative mechanism. In this sense symptomatic management may accomplish the same end as sympathectomy and, with about the same frequency, with the essential difference that the effect of sympathectomy in some patients may be more marked and more prolonged. Neither method of treatment presumes to eliminate the primary cause. While relief of subjective symptoms may completely rehabilitate a hypertensive patient, mere lowering of the blood pressure level without relief of symptoms serves no such purpose. This is not to imply that a lowered blood pressure is necessarily without some benefit, but rather that it is not to be considered the prime objective of a plan of symptomatic management.

Perhaps the most valuable single device in the rehabilitation of the hypertensive patient is psychotherapy; the planned and detailed methods employed by the psychiatrist are not necessarily superior to repeated conferences with a sympathetic physician who will give attention to problems responsible for emotional instability. A physician properly trained in general medicine and with an interest in psychiatry is competent to undertake such treatment and beneficial results are often obtained in a relatively short time. Often simple, sympathetic reassurance is sufficient to relieve disturbing symptoms. It should be explained to the patient that high blood pressure and longevity are compatible and that elevated blood pressure is a symptom and not a disease. As far as possible the patient's attention should be diverted from fixation on the exact level of the blood



pressure to the cultivation of intelligent habits of living. The physician can foster this attitude by prolonging the interval between examinations, particularly in the early uncomplicated period when symptoms are few or absent. Psychotherapy intelligently applied often results in dissipation of the anxiety, depression and irritability which accompany the phobia of high blood pressure.

Patients with uncomplicated hypertension tolerate ordinary exercise well; however, they should not exceed their tolerance and should be advised to avoid vigorous and competitive sports. For those who lead a sedentary life, mild exercise compatible with the patient's tolerance should be encouraged. Occupations involving constant emotional tension are best modified by shortening the hours of work or by dispelling the urge to excel. In most instances it is unwise to suggest complete retirement when modification and partial curtailment are feasible.

The diet in uncomplicated hypertension requires no essential change from the normal. There is no justification for restriction of protein intake, as suggested by the recently introduced, rice diet. Likewise, in the absence of edema or paroxysmal dyspnea, the restriction of salt is unwarranted; claims that such restriction may favorably influence the course of hypertensive disease have not been substantiated. Obesity should be avoided for the same reasons that apply to normal individuals and not because of any demonstrated relationship to hypertensive disease. Tobacco is best interdicted, particularly in those who show evidences of vascular insufficiency, as anginal pain and intermittent claudication. Coffee and tea may be permitted. Alcohol in frequent small amounts should be encouraged for its beneficial vasodilator effect. Mild sedation may be useful in conjunction with the above symptomatic measures.

#### NEUROLOGICAL COMPLICATIONS

##### HEADACHE

The characteristics of the severe and often incapacitating headache in hypertensive disease are well known. It is particularly resistant to treatment in most instances. The usual remedies such as acetylsalicylic acid, phenacetin, or codein frequently fail to effect relief. It may subside spontaneously or require a period of sleep induced by morphine. Although spinal fluid pressure is usually not increased, temporary relief may follow its slow removal; however, this method is not without some danger in those in whom there is increased intra-

cranial pressure and should be resorted to only as a final measure. Occasionally relief is obtained from the intravenous administration of 2 grams of magnesium sulphate in a 10 per cent solution. Prolonged relief from episodes of headache frequently follows extensive sympathectomy, even when the blood pressure has not been lowered.

##### ENCEPHALOPATHY

Since the episodes are transient, no particular treatment is necessary for the acute episodes. For repeated convulsive seizures the treatment is similar to that suggested for headache.

##### SUBARACHNOID HEMORRHAGE

In the majority of patients with this rare complication of hypertensive disease, recovery follows after a few weeks of absolute bed rest. Marked and persistent rigidity of the neck, blurring of the discs, or intense headache indicate the necessity for repeated slow removal of spinal fluid.

##### CEREBRAL HEMORRHAGE AND THROMBOSIS

When coma occurs at the onset, the patient should be placed in the semi-recumbent position, and clothing about the neck should be loosened. The head should be turned to one side to prevent the tongue from slipping backward; this together with gastric lavage may reduce the possibility of inhaling vomited material. Prompt venesection of 300 cc. to 500 cc. is indicated in plethoric patients when there are evidences of increased intracranial pressure, such as bradycardia or swelling of the optic discs. Repeated convulsive seizures may be benefited by intravenous or intramuscular administration of magnesium sulphate as discussed above; spinal tap may occasionally be necessary but the fluid should be removed slowly with recognition of the possible danger of further bleeding from too sudden or too great reduction of intracranial pressure. When vomiting is severe and protracted, clysis or slow infusion of isotonic saline is necessary to combat dehydration and hypochloremia; after the first twenty-four hours glucose should be added to the infusion. Fluid or food by mouth should be withheld until the patient is able to swallow without difficulty. During the period of coma, strict attention to oral hygiene is essential because of the danger of insufflation of particulate material. Retention of urine is common, requiring bladder catheterization at intervals of about twelve hours; if evidence of cystitis appears, appropriate therapy should be insti-

tuted. Marked intestinal distension should be treated by periods of colonic syphonage. The prevention of bed sores requires constant attention to the skin: frequent turning of the patient to opposite sides, avoidance of pressure on bony points by means of rubber rings or cotton padding, and the use of bland powders, alcohol, and gentle massage. Marked restlessness is often controlled with 0.6 gm. of chloral hydrate by mouth at intervals of three hours or by 8 cc. paraldehyde by mouth in repeated doses, or it may require parenteral administration of 0.2 gm. of sodium luminal repeated as necessary; morphine should be avoided since it may increase intracranial pressure.

When consciousness has returned the patient may be permitted to sit up in bed and small frequent feedings may be begun. When some degree of motion has returned, the patient should be transferred to a wheel chair for intervals during the day and, when feasible, he should be encouraged to stand or walk with the required amount of support; in the great majority of instances this degree of progress is achieved within two to three weeks from the onset.

Passive movements should be started early and active movements as soon as feasible. Daily brisk massage is beneficial; electrotherapy is of doubtful value and may discourage the patient from attempting the more beneficial voluntary movements. The tendency toward muscle contraction may be corrected to some degree by the proper application of mechanical supports.

Treatment in the subsequent period is essentially a matter of re-education; the patient should be encouraged to walk since in most instances there is sufficient return of function in the leg. While the function of the hand is apt to be more seriously impaired, its grasping motion may often be retrained and even the ability to write may be restored in part. The period of re-education is long, in most instances requiring a year or more of patient effort.

#### RENAL COMPLICATIONS

The kidneys are rarely involved to a significant degree in hypertensive disease; only about 8 per cent of patients with essential hypertension die of uremia. While renal arteriosclerosis is almost invariably present late in the course of the disease, no particular treatment is indicated apart from that discussed under general measures.

The management of uremia in hypertensive

disease is similar to that in any of the renal diseases. During the period when symptoms are absent, no treatment is required; when symptoms appear the most useful therapeutic measure is parenteral administration of saline to combat dehydration and hypochloremia. When heart failure is present, even this valuable measure must be limited to the amount that can be tolerated without precipitating pulmonary edema. It should be recognized that while the maintenance of a high urine flow by this means frequently results in a lowering of the blood urea concentration, this effect should not be construed as evidence of improvement in the basic disturbance; indeed, the symptoms of uremia may progress to coma and death in spite of extreme reduction of the blood urea concentration induced by diuresis and protein restriction. Sodium salts should be restricted in the presence of systemic or pulmonary edema. While the symptoms of uremia may subside for a time in those patients in whom an acute and reversible lesion has been superimposed on previous disease of the kidneys, as in acute exacerbation in chronic glomerulonephritis, such regression is not to be anticipated in hypertensive disease in which uremia is precipitated by the occurrence of irreversible necrotizing renal arteriolitis. The treatment, therefore, is directed toward symptoms as they arise for the patient's comfort, but with no expectation of influencing the final outcome.

#### CARDIAC COMPLICATIONS

In the asymptomatic phase of hypertensive heart disease, treatment consists mainly in the avoidance of excessive physical activity and emotional conflicts. Exercise such as walking or golf is beneficial for those with adequate cardiac reserve. Sedatives such as phenobarbital, bromides, or chloral hydrate may be used to alleviate anxiety; emotional conflicts should be treated with appropriate psychotherapeutic measures. Over-indulgence in tobacco may induce anginal pain and disturbances in rhythm.

The treatment of heart failure in hypertensive disease is similar to that for congestive heart failure in heart disease of other etiology. The essential features are bed rest, oxygen, digitalis, diuretics, sodium-poor diet, and sedation.

Auricular fibrillation may occur in paroxysmal episodes in hypertensive heart disease over a period of a year or more before becoming permanently established. If these attacks are not associated with heart failure, they are frequently controlled with



quinidine. On the other hand, if auricular fibrillation results in myocardial failure, quinidine should not be employed, digitalis being the drug of choice. It should be administered to the point of full therapeutic effect, or until signs or symptoms of intoxication appear. The patient should subsequently be kept on a maintenance dose, using the ventricular rate as a guide to optimum dosage.

Gradual failure of the left ventricle in hypertensive heart disease manifested by fatigue and exertional dyspnea is treated with digitalis. When the left ventricular failure is acute in onset with paroxysmal dyspnea, the treatment consists of the administration of morphine hypodermatically and high concentrations of oxygen. If these measures fail, phlebotomy should be performed. A mercurial diuretic, at intervals intravenously, is of value in the treatment of chronic left ventricular failure.

In many instances of recurring cardiac pain, bed rest and sedatives are necessary. Alcohol repeated in small amounts during the day is often helpful. Following the period of bed rest, the patient may be allowed up and about with gradual return to usual activities; control of activity at the point where the anginal syndrome does not occur is essential. If the anginal syndrome persists or reappears despite these restrictions, other therapeutic measures are indicated. The most useful are the nitrites and of these, amyl nitrite and nitroglycerine are the most effective. Tissue extracts have generally proved to be ineffective.

For patients in whom cardiac pain is intractable, alcohol paravertebral block of the dorsal sympathetic ganglia from D2 to D6 inclusive and of the stellate ganglion is indicated. This procedure is occasionally followed by prolonged intercostal neuritis. Patients who have been relieved of pain by this means should be cautioned in regard to strenuous physical or emotional activity since they no longer can depend upon cardiac pain as a check on their reserve. In the majority of patients, cardiac pain is either relieved or replaced by a more tolerable sensation, such as pressure.

Attempts have been made to alleviate persistent cardiac pain surgically by increasing myocardial blood flow. The operative procedures used are cardio-omentopexy, cardio-myopexy, and cardio-pericardiopexy. The clinical results have not been encouraging. Furthermore, there is no evidence that the new blood vessels which may develop in the operative area are functionally effective.

The introductory symptom of severe substernal pain or oppression in acute myocardial infarction requires the immediate administration of morphine and atropine. Oxygen should be administered in high concentration; it is particularly useful in patients who present shock or restlessness and severe pain not relieved by opiates.

Complications of myocardial infarction usually occur in the first three weeks. Among the more important are arrhythmias, heart failure, and embolism.

Premature systole is the most common arrhythmia during the early period. If it appears only occasionally and does not annoy the patient, it may be disregarded. However, if it occurs frequently, treatment with quinidine should be instituted. Ventricular tachycardia should be suspected when rapid heart rate with regular rhythm suddenly develops. The patient usually complains of a fluttering sensation in the chest and becomes extremely dyspneic. Treatment consists of the administration of morphine and quinidine. Often the paroxysm subsides spontaneously. Auricular fibrillation may occur at the onset of myocardial infarction. The majority of attacks are of short duration and end spontaneously. For patients in whom it continues for days, quinidine is indicated. If heart failure develops, the drug of choice is digitalis.

Cardiac insufficiency as a complication of myocardial infarction in a patient with hypertensive and arteriosclerotic heart disease may manifest itself in one of two forms: acute left ventricular failure with paroxysmal dyspnea, or gradual appearance of congestive heart failure. The measures employed are similar to those described for heart failure in the absence of myocardial infarction.

In contrast to the other complications which usually occur within the first three weeks, embolism may occur at any time. The treatment of choice is immediate intravenous injection of papaverine, 0.1 to 0.2 gm. repeated in two hours if necessary. Paravertebral sympathetic nerve block is of benefit in some instances where embolism involves the vessels of the extremities. Embolectomy is contraindicated as too hazardous in the presence of a fresh myocardial infarct.

#### CONDUCT OF ANESTHESIA IN THE HYPERTENSIVE PATIENT

When a surgical procedure is indicated in a hypertensive patient, the proper management of

anesthesia is of prime importance. In those patients in whom elevated blood pressure is not associated with advanced vascular disease the conduct of anesthesia does not differ from that used for normotensive individuals. However, when elevated blood pressure is associated with advanced vascular disease, precautions are necessary to avoid hypoxia and extreme variations in the level of blood pressure.

Hypoxia may result from agents which depress respiration such as excessive dosage of morphine or the anesthetic drugs nitrous oxide and ethylene, which cause inadequate arterial oxygen saturation.

Acute increase in the level of blood pressure may occur during the excitement phase of induction with nitrous oxide or ether and acute fall during high spinal anesthesia. Excessive accumulation of carbon dioxide due to faulty absorption technic may also induce acute marked elevation of the blood pressure level.

As with normotensive individuals, no standardized regime for the conduct of anesthesia can be prescribed for hypertensive patients. They must be individualized in regard to the nature of the surgical procedure as well as the condition of the patient at the time of operation. When there are no surgical indications for variation from a standard procedure, the following anesthesia regime is recommended to reduce the probability of occurrence of hypoxia and marked variation in the blood pressure level. The purpose of pre-anesthetic medication is to allay autonomic excitation and decrease metabolic activity, as a result of which smaller quantities of anesthetic are required; morphine sulphate in combination with scopolamine is used for this purpose. It should be administered not less than one hour and a half preoperatively; if it is administered too close to the time of operation, its intended preoperative sedative effect is lost and its maximum effect will occur at the undesirable time of profound anesthesia, tending to exaggerate respiratory depression. Avertin in small dosage may be employed to produce basal anesthesia as a pre-anesthetic measure.

Of the inhalation anesthetics, cyclopropane is the drug of choice, since it is administered in the presence of high concentration of oxygen. There is no contraindication to ether, provided the excitement stage is avoided. A particular advantage in inhalation anesthesia is that the agent may be administered through an endotracheal airway which allows for the prompt administration of oxygen under pressure if an emergency should arise.

Although spinal anesthesia is not the method of choice, it may be used when inhalation anesthesia is contraindicated. Spinal anesthesia involving the lumbar and lower thoracic nerves can be employed in the hypertensive patient with the same degree of safety as in the normotensive individual. However, respiratory depression and marked fall of blood pressure that may accompany high spinal anesthesia make this extent of block undesirable for the hypertensive patient.

#### TREATMENT OF THE SPECIFIC HYPERTENSIVE DISEASE OF PREGNANCY

In the majority of patients who develop the specific hypertensive disease of pregnancy, the first clinical evidence is inordinate gain in weight. This may occur before subcutaneous edema is clearly evident and before either proteinuria or hypertension appears. At this stage, rigid restriction of sodium intake is indicated. The patient may continue ambulatory under observation. If hypertension appears later, bed rest is essential. When the blood pressure returns to normal on bed rest and sodium restriction, the patient may be allowed up and about; frequent re-examination should be made with particular regard to the blood pressure. Return of significant hypertension requires a further period of bed rest. If the blood pressure continues to rise in spite of these measures, decision must be made as to whether to continue medical treatment or interrupt the pregnancy. This decision is influenced mainly by the month of pregnancy in which the complication occurs. If the pregnancy is in the early part of the third trimester, it is extremely unlikely to result in a viable fetus, so immediate artificial interruption is indicated. If specific hypertensive disease occurs in the latter part of the third trimester, conservative measures should be continued until the fetus is viable, at which time the uterus should be emptied artificially. It is unwise in this instance to await spontaneous labor since many intra-uterine fetal deaths occur in the last few weeks of pregnancy. If during this period of conservative treatment retinal hemorrhage or detachment appears, the pregnancy should be promptly interrupted.

Apart from the decision as to the advisability of artificial interruption of pregnancy, treatment of the individual symptoms in specific hypertensive disease of pregnancy is similar to that employed in hypertensive disease in the non pregnant individual.

The treatment of convulsive seizures and acute left ventricular failure has been discussed. Either of



These complications constitutes a distinct contraindication to artificial termination of pregnancy until the episode is well under control. These patients are best treated conservatively since symptoms almost invariably occur close to the period of viability of the fetus and since artificial interference during or too soon after these episodes is attended by an inordinately high morbidity and mortality rate for both mother and child.

Proteinuria is not subject to therapeutic control, but depletion of plasma protein should be combatted by an increased protein intake.

Since an episode of specific hypertensive disease usually predisposes to recurrence, it is generally unwise to permit another pregnancy. However, if proteinuria, edema, and hypertension have been absent for a period of at least one year, a subsequent pregnancy may be permitted. In these patients, prompt interruption of pregnancy is indicated at the first appearance of evidences of specific hypertensive disease.

The existence of essential hypertension or chronic primary renal diseases, such as chronic diffuse glomerulonephritis, does not constitute a contraindication to pregnancy since they are compatible with continuation of pregnancy to viability; furthermore, they do not predispose to specific hypertensive disease of pregnancy and are not themselves aggravated by pregnancy. However, since in these patients intra-uterine fetal death is apt to occur late in pregnancy, it is advisable to artificially terminate pregnancy close to term. On the other hand, when cardiac, cerebral, or renal functional impairment occurs in patients with essential hypertension or chronic primary renal disease, pregnancy is contraindicated.

#### SUMMARY

In reading this paper it was my intention to enumerate the surgical measures and so-called specific

medical measures which have been suggested for the relief of human hypertension and subject each to a critical analysis. Personal experience has been combined with the experience of others and as you have gathered, we have arrived at a disappointing conclusion. It should be remembered that this conclusion is colored by our own observations and that there are others who do not share our pessimistic attitude toward all the therapeutic measures we have discussed. While the present approaches appear to have fallen short of expectation it may well be that they will lead to further procedures and modifications with more promise.

However, it is our present considered opinion that with rare exceptions, any treatment based upon the assumption of similarity between experimental and human hypertension is doomed to failure. And furthermore, that any treatment directed solely toward temporary reduction of blood pressure is unsound. The final treatment will come only when the causative mechanism of human hypertension is discovered and specific measures are devised for its elimination.

Because it is familiar to you, I have sketched in brief those measures which comprise the symptomatic management of hypertensive disease. While these measures are admittedly inadequate they serve the invaluable purpose of focusing attention on the patient as a whole rather than on a single symptom of his disease, i.e. elevated blood pressure. All of us who practice clinical medicine know how valuable these simple measures can be in returning many patients to a productive and contented life. Their value must not be minimized and we should become more proficient in their application until a specific treatment is evolved.

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## RHEUMATIC HEART DISEASE

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**R**HEUMATIC FEVER and rheumatic heart disease are taken as a clinical entity, for rheumatic heart disease may well be described as the result of the progressive and usually permanent structural changes in the heart due to rheumatic fever. In the review of this subject and the study of very recent statistics concerning this disease compiled by the American Heart Association, various health departments, and insurance companies, several striking conclusions stand out. First, this disease presents an important medical problem and has a tremendous social and economic influence on the population of this country. Secondly, at the present time, we have no definitely proven, generally accepted, well established etiology of this disease. And we have no specific treatment for it.

<sup>1</sup>It is estimated that there are each year in the United States between 200,000 and 260,000 cases of rheumatic heart disease with an estimated rate of 1,500; 2,000 new cases yearly; and annually 30,000 to 60,000 deaths resulting from this disease. <sup>2</sup>It is the commonest cause of death between the ages of five and nineteen and the second commonest cause in the age group nineteen-twenty-four. The average duration of life from the initial attack is fifteen years, and the life span of those patients with rheumatic fever and rheumatic heart disease is given as 36.5 years as compared to fifty-five years for the general population. About seventy-five per cent of all rheumatic fever cases developed chronic deforming valvar diseases. After a period of ten years following the first attack, a period given as the average time interval from the attack to the appearance of cardiac insufficiency, out of a thousand cases it was found that 439, or less than one half, followed normal activities. About one-third, or 344, had impaired activities ranging from slight to moderate, and to marked degrees, and about one-fifth (203) were dead. As compared to six other common infectious diseases a New York City Health Department report a few years ago showed that there are 1,105 deaths from rheumatic fever and heart disease as compared

to 105 from whooping cough, meningitis—53 measles 42, diphtheria 26, scarlet fever 17, and 2 from infantile paralysis.

It is remarkable how we have had so much publicity, drives for funds and interest shown for infantile paralysis, and so comparatively little for the much more serious and fatal disease, rheumatic fever.

The acute attack is most common in the United States in late winter and in the fall months; in the fall and winter months in England. It is common to cold, damp climates, much less common in subtropical climates and rare in the tropics. Children of poor families with poor hygienic living conditions are much more susceptible to the disease than other children. Those subject to cold, dampness, exposure, crowding, and dietary deficiencies are more apt to contract this disease than others. About thirty per cent of the cases begin in the post adolescent period. Those who have had previous attacks are three to four times more susceptible to subsequent ones when subject to streptococcus infections, than those who have had no previous attacks.

There is frequently a prodromal period characterized by lethargy, obscure symptoms sometimes bone pains. Fifty per cent of the attacks are preceded by sore throat, most often tonsil infections. There may be no prodromal stage, the fever coming on after body chilling or some depressing influence, followed in twenty-four hours by severe prostration, and fever from 102 to 104 degrees, polyarthritis and pronounced toxemia. About fifteen per cent of the cases may have no recognized attack of rheumatic fever but develop rheumatic heart disease.

It is generally agreed that some form of hemolytic streptococcus is the organism cause of this disease. More recently a group A BETA hemolytic streptococcus has been considered the organism that is chiefly responsible for causing the acute attack. There is much that is not known as to just how this organism establishes itself to cause the acute process and the pathologic lesions that follow. This is the



phase of the disease that is being widely discussed and about which many theories are being investigated. At present, there is not sufficient knowledge to adequately assure prevention of disease or to establish a specific treatment. Without going into the bacteriological theories and the non specific causes in detail, for much of this is subject to dispute and much study at present, there appears besides the specific organism, certain non specific causes, as malnutrition, crowding, cold and dampness. With these conditions and recurrent infections with the hemolytic streptococcus from infections usually of the throat, upper respiratory tract, and sinuses which produce sensitization to this organism, group factors are established that favor the deconating effect of the specific hemolytic streptococcus and the occurrence of the acute phase of rheumatic fever. There are other factors that possibly work synergistically with some unknown agent such as a filtrable virus that may induce the disease.

The pathology of the acute attack is characterized by the appearance of minute focal proliferative lesions in certain tissues—proliferative and exudative arthritis; proliferative endocarditis (valvulitis); sometimes pericarditis, pleurisy, and intercurrent pneumonia; the lesion being a submiliary granuloma resulting from the fibrinous swelling in the connective tissue combined with granulocytosis. These granular bodies form in ten to fourteen days after the start of the attack. Variations in the size and location of which and their stage of development account for the pathological picture of the disease. The typical lesion of rheumatic valvulitis is a grayish pink verruca on the surface of the valves, usually, on the line of contact with opposing cusps. These vegetations consist of fibrin enmeshing various cellular blood elements deposited on the part of the valves from which the endothelium has been denuded. Various changes in the pathological picture take place through the duration of the disease resulting finally in thickened scarred areas with less flexibility of the valves and areas of lessened resistance to subsequent infections. Besides the endocardium, the pericardium, myocardium, joint membranes and the pleura may be involved in similar pathological processes.

Depending on the type of disease, monocyclic, polycyclic or continuous, the acute phase may last from two weeks to many weeks. Cardiac involvement is the most common feature of rheumatic fever. Ninety-five per cent of all the cases show

transient changes in the EKG, various arrhythmias, pulse rate changes, and various degrees of cardiac insufficiency during the course of the disease.

The diagnosis is made upon the symptoms and the course of the disease. There is no characteristic laboratory tests. There is a leukocytosis from 15 to 25,000 and a sedimentation rate from 100 to 130. These gradually reduce with recovery. A leucytosis and persistent sedimentation rate of 30 to 60 mm shows a persistent infection. A sedimentation rate over 25 mm indicates that more treatment is required.

The residue of the heart damage which occurs in three-fourths of all rheumatic fever cases, is some form of chronic, deforming valvular disease and myocardial damage. The results are usually in the form of scarring of the valve cusps and chordae tendinae with thickening, adhesions of the cusps, fusion of a whole valve, and sometimes calcification. The mitral valve is most commonly affected in proportion of 100 to the aortic 50, and tricuspid valve 25, and the pulmonary valve less than one.

For the treatment of this disease we must rely upon massive doses of the salicylates, 45 grains of sodium salicylate daily for children to 150-160 grains for adults. Besides the drug therapy, prolonged bed rest and good nursing, good nutrition, and symptomatic treatment of the disease comprise the generally accepted present methods. The exact way in which the salicylates produce their effect is not known. They produce lessening of the joint swelling, reduction of fever and pain, but do not shorten the duration of the attack nor the incidence of valvulitis. The use of sulfa drugs and penicillin has been completely disappointing. The use of sulfa drugs may be dangerous during the acute stage. Once the hemolytic streptococcus infection has taken place, the sulfa drug will not prevent rheumatic fever. Except for the treatment of streptococcus infection, which may be preventive, penicillin has not proven helpful in treating rheumatic fever.

<sup>3</sup>Rheumatic fever has been a particularly prevalent disease in the military population during World War II. Figures released by the Office of The Surgeon General of the U. S. Army indicate that approximately 17,000 cases of rheumatic fever occurred in that branch of the service from January 1941, until August 1, 1945. The Bureau of Medicine and Surgery of the United States Navy has indicated that from the onset of the war up to January 1,

1945, 14,344 cases of rheumatic fever occurred in that branch of the service. During the same period the Office of the Air Surgeon has estimated that thousands of cases occurred in the air forces, although an exact figure has not been released. The majority of the attacks of rheumatic fever among members of the Armed Forces occurred in individuals who had no history of previous attacks of rheumatic fever.

The importance to the Veterans Administration of a review, and a digest of reports of the incidence of this disease, its pathology, the tendency toward recurrence and the chronic nature of rheumatic heart disease, seems timely. Presently and for years to come, many thousands of the soldiers of World War II who have had rheumatic fever will require re-examination, ratings for pension purposes, and medical care.

It is the purpose of this report to focus attention to the chronicity, and clinical nature of rheumatic

heart disease, that the physical examinations and special examinations by cardiologists may be of greater value than if made in a routine way.

For a disease of such medical and social importance we are only now taking vigorous active steps to initiate an extensive program of medical research and intensive study of this disease. This is, however, being widely conducted at present; the work of the various research groups being coordinated by the Council on Rheumatic Fever, created by the American Heart Association—a research step long overdue.

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## THYROID LUMPS

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**T**HE CURRENT trends in medical therapy forebode an increase in the incidence of thyroid lumps and our decrepit diagnostic methods do not stand up even under the present burden.

A definition, of course, is that any enlargement of the thyroid gland is a thyroid lump but when I talk about increase in incidence I am not talking about those of hyperthyroidism or those which cause pressure in the neck. I am talking about the ultimate of thyroid lumps, those that when neglected cause death, malignant lumps.

To justify the statement that present trends in therapy may increase the incidence of carcinoma of the thyroid which is already not an uncommon disease, I should give you the statistics to decimal places of the present incidence of carcinoma of the thyroid. I cannot do this; I have no reliable statis-

tics. I will give you two points of view, perhaps the extremes.

The other day I spoke to Dr. Astwood, who as you know introduced thiouracil. I know that in the past three years he has supervised the treatment of at least 250 cases of goiter, yet he told me he had never seen carcinoma of the thyroid and that its incidence is, in his opinion, grossly exaggerated. I on the other hand, in the past 14 months have either myself operated or have supervised the resident surgeons in operations of approximately 250 cases of different kinds of goiter and in that group I operated personally on 15 cases of carcinoma of the thyroid and the residents on two others.

Dr. Astwood has referred to him cases of thyrotoxicosis, a group in which carcinoma is seldom found. On the contrary, in my hospital, surgeons are now interested in malignancy of the thyroid and somehow carcinoma cases find their way to us. In spite of the discrepancy between Astwood's and my own experience, I trust you will accept the

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premise that carcinoma of the thyroid gland is not uncommon.

My medical colleagues tell me that medical methods will soon have taken the treatment of thyroid disease from the surgeon's hands. At the present time that is speculation on their part. Now I would like to deal in a little speculation, too, regarding the consequences of the present medical therapies.

As you know in the past three years, two methods of treating patients with thyrotoxicosis medically have been introduced. Both methods are immediately successful but both may have later consequences. The first of these treatments is thiouracil as introduced by Astwood. This drug blocks the formation of the thyroid hormone and when given to a patient with thyrotoxicosis it relieves the patient of the hypermetabolism or excessive production of thyroid hormone. In doing so, however, it apparently does not halt the disease process for with the drop in metabolism there is an increase in the anatomic disorder of the thyroid gland. In the patient with the common type of hyperthyroidism, or Graves' disease, associated with diffuse hyperplasia of the thyroid gland all of the features of the hyperplasia are intensified by thiouracil. The cellular proliferation, the papillary infoldings and mitotic figures are increased, sometimes to the extent of imitating a papillary adenoma. A section of the gland of one of our patients was diagnosed as carcinoma by the pathologist though this was not true.

Other features of the hyperplastic disease, such as colloid vacuolization, lymphoid hyperplasia, and vascularity are also increased. In other words thiouracil intensifies the anatomic disorder in contrast to iodine which reverses all of the anatomic and vascular changes bringing them back toward normal. This intensification we have proven by multiple biopsies of the goitres of patients with Graves' disease before and after thiouracil therapy.

It is true that if thiouracil therapy is continued long enough the patient with hyperthyroidism is apparently completely relieved of the excessive secretion of thyroid hormone. If the drug is omitted immediately following the return of the metabolic rate to normal, there is usually a prompt recrudescence of the hypermetabolism. If the drug is continued for from a few to several months and its administration gradually tapered off, the hypersecretion does not recur. The goitre, however, remains so that although patients treated medically

with thiouracil may be relieved of the active phases of the disease, an anatomic abnormality remains.

The second non-operative treatment of hyperthyroidism is that with radioactive iodine introduced by Hertz and Chapman of the Thyroid Clinic at the Massachusetts General Hospital. The use of radioactive iodine in the treatment of hyperthyroidism is based upon two principles. The first that the affinity of the thyroid gland for iodine applies equally to the radioactive isotope and the non radioactive molecule of iodine. The second is that radiation is an effective means of destroying thyroid tissue.

The thyroid of the human being, like that of the experimental animal, has been found to take up radioactive iodine. The hyperplastic, hyperfunctioning goitre which is avid for iodine absorbs radioactive iodine in large quantities, indeed, 80 per cent to 90 per cent of that ingested. Irradiation of the thyroid gland can therefore be controlled by administering a given dose of radioactive iodine which can be measured to have delivered a certain radiation to the thyroid gland. A number of patients have now been relieved of their hyperthyroidism and their goitres have been observed to disappear.

Doses of irradiation, large enough to produce an initial inflammatory reaction within the thyroid, are necessary for complete relief. Small doses are ineffectual. The patients receiving an adequate dose notice a discomfort for a few days, the thyroid gland enlarges, perhaps doubles in size, and becomes tender and there may be a feeling of oppression. Gradually the swelling disappears, the goitre decreases in size, and the thyrotoxicosis wanes. If the initial dose was not large enough, a second dose may be effective in bringing the metabolic rate to normal. Of the 35 cases so far effectively treated, none has had a full blown post-irradiation myxedema. Therefore some epithelial tissue remains in the thyroid of each patient.

Little is known of the anatomic effects of the irradiation, for biopsies before and after the administration of therapeutic doses of radioactive iodine have not been done as they have with thiouracil. We have therefore only animal experiments to go by. In the thyroids of experimental animals rendered hyperplastic and avid for iodine by the administration of anterior pituitary extract, radioactive iodine causes a diffuse fibrosis and destruction of thyroid cells. Certain it is that in the human being with a goitre causing hyperthyroidism a profound physical

effect is produced whenever a dose of radioactive iodine, large enough to cure the hyperthyroidism, is administered.

The question is: What will happen in the thyroid glands of patients after thiouracil and radioactive iodine treatment? Will there be an increased incidence of carcinoma as a result of either therapy? In regard to the glands treated with thiouracil: It is clear that carcinoma is a rare accompaniment of diffuse hyperplasia. I personally have seen four cases of adenocarcinoma occurring in patients with the diffuse hyperplasia of Graves' disease. The carcinoma was an incidental finding at operation, wholly unexpected and presumably took no part in the hypersecretion. But was the carcinoma initiated by the hyperplastic process? This we do not know. Is there any experimental evidence bearing on this question? Bielschowsky in England has shown in rats that thio-allyl-urea, a drug closely allied to thiouracil, has the propensity when given along with a carcinogen which normally does not affect the thyroid, to initiate carcinoma of the thyroid. Other experiments by Rawson using thiouracil show adenoma formation in animals and, indeed, we have seen some adenoma-like lesions in human thyroid specimens after long use of the drug. We do not know how big the jump is from a benign to a malignant neoplasm and to what extent we may translate the observation in the rat to the human being.

In regard to the glands left in patients after treatment with radioactive iodine: Although the goitre disappears if enough iodine is given, what will happen to the remnants in the time to come? It must be recalled that the thyroid gland is an epithelial organ, that it is a tissue susceptible to carcinomatous degeneration, and that in other epithelial organs irradiation sufficient to cause necrosis is followed by an alarming incidence of malignant degeneration in later years. The incidence of malignancy of the skin twenty years following a necrosing dose of irradiation is such that the x-ray department of our hospital will not irradiate a non-malignant lesion of the skin. In the past few years many people, and this applies particularly to children, whose nevi or hemangiomas of the skin were treated by irradiation twenty to thirty years ago, have returned with malignant lesions in the site of the irradiation.

There is no other organ in which we have experience comparable to that following irradiation of the skin but from all that is known of the effect of irradiation in its production of experimental tumors

it would not be possible to disregard the possibility of malignant degeneration of the thyroid years hence following massive destructive internal irradiation of the thyroid by radioactive iodine isotopes.

Both thiouracil and radioactive iodine are effective tools in the treatment of thyrotoxicosis; they are brilliant discoveries. Already they have found their uses in the treatment of thyrotoxicosis. As a surgeon, I am much interested in what they have already taught us regarding thyroid disease. The use of either as the sole treatment of thyrotoxicosis however, demands a careful and prolonged follow-up of the patient to exclude the development of malignant change. In carrying out such a follow-up what diagnostic procedures can we depend upon? Let me illustrate by what happened a short while ago.

One of our physicians called on the telephone and asked me to come down to his office and see a patient. When I arrived he was out in the corridor waiting for me, obviously agitated. He told me the following story, before I saw the patient. She was a daughter of one of the Harvard faculty and first came to him three years before at the age of 20 with a lump in the lower pole of the thyroid. It was small. She was just recently married, her husband was in the Air Corps, she was moving to Cleveland and he could see no reason to remove it. Statistically the chances were it was innocent and he wisely and properly referred her to a professor of medicine at Cleveland who said, yes, it was probably innocent but that he would watch it along. When, some six months later she moved to New York, he properly referred her to a physician in New York. The third physician also couldn't make much more out of it and said to leave it.

She then became pregnant and, during pregnancy the lump increased fairly rapidly in size and, at the termination of pregnancy, the lump did not recede. With the end of hostilities, the patient returned home to Boston and because this lump felt larger she returned to see the first physician.

Now, in those three years it had changed. It was firm, almost hard; it was bigger and fixed, and the physician was rightly fearful that it was malignant and that he had not exercised proper judgment and due caution when he first saw the patient; he was greatly disturbed. Since it had all the characteristics I couldn't say it was not malignant but there was a pretty good chance that on a statistical basis it was not. My first duty was to reassure the physician



who was far more agitated than the patient. She had the operation and, as it turned out, this particular lump was not malignant.

It is a sad commentary that the sole diagnostic procedure upon which we can count with certainty is operation.

The majority of thyroid lumps are innocent yet in order to exclude malignant disease it is often necessary to operate. Is there any way in which we could improve the objectivity of making a diagnosis without operation? Let me tell you what we have been doing at the Massachusetts General Hospital in an effort to improve our diagnostic acumen.

First of all we have explored the possibility of a difference in functional activity between malignant and non-malignant lumps. Recent surveys of large groups of cases of thyroid disease have intimated that malignant tumors are never associated with hyperfunction. This carries with it the suggestion that malignant tumors are nonfunctioning.

Radioactive iodine, in tracer dose only, offers an ideal method to test such a suggestion. If malignant tumors are nonfunctioning no radioactive iodine should be found in the malignant tissue in contrast to the uninvolved tissues. The last 78 patients in the Thyroid Clinic of the Massachusetts General Hospital having a single nodule, or nodules limited to one area of the thyroid gland, have been given a mere tracer dose of radioactive iodine within forty-eight hours before operation. At operation the localized disease has been excised and a portion of the uninvolved thyroid tissue has been removed as a radioactivity biopsy. Careful search has been made at operation for spread of the disease process to the lymph nodes and where present the involved lymph node has also been tested for its content of radioactivity. In cases with malignant spread to the lymph nodes, search has been made with a Geiger Counter over the entire body following the tracer dose of radioactive iodine.

This study has brought two things to light. The first is that both malignant and non-malignant localized tumors have functional capacities of varying degrees. This finding, unfortunately, does not help us diagnostically at the present, but it is informative regarding the nature of tumors and is already being helpful as a therapeutic tool.

The second point which the studies with radioactive iodine in localized tumors tells us is the incidence of malignant disease in patients showing

evidence of localized changes in the thyroid gland. Of 78 patients seen in the last 14 months with enlargement of the thyroid gland in only one area, that is with the remainder of the thyroid gland uninvolved as determined by physical examination and confirmed by operation, 17 cases proved to have true malignant disease. This is alarming for it is an incidence of 22 per cent.

This incidence of 22 per cent is not the incidence of malignancy in all goitre nor in all enlargements of the thyroid without thyrotoxicosis. It is the incidence in a selected group of patients with nodular goitre without hyperthyroidism.

If a patient has hyperthyroidism with a diffuse non-nodular goitre the incidence of malignancy in that goitre before therapy is low. If the patient has a nodular goitre with or without hyperfunction and with the nodules diffusely distributed throughout the gland, the incidence of malignancy before any therapy is still low. If, however, the nodular character is localized to one area of the gland, whether the nodule be single or multilobed in character, the incidence of malignancy is very much higher and in our series at the present is 22 per cent.

Using this criterion of localization, which can be correctly determined on physical examination, we can logically reassure a patient with a diffuse goitre and often postpone operation in the absence of hyperfunction. But in a patient with evidence that the disease process in one area is outstripping that of the rest of the gland, operation is advisable within a reasonable period. We physicians should realize that the operation is primarily to make a diagnosis; the removal of the nodule is secondary for its importance depends upon the diagnosis.

What will happen to the thyroid gland after prolonged thiouracil therapy or after irradiation with a therapeutic dose of radioactive iodine, time alone will tell. I hazard the guess that in the thiouracil treated patients the incidence of malignancy in the residual goitre will be slightly increased. What will happen in the thyroid gland shrunken after heavy irradiation from radioactive iodine takes on a graver hue in my speculative vision. Unfortunately it may require the passage of twenty years before we begin to know the answer.

I have mentioned that both thiouracil and radioactive iodine are useful tools in the treatment of thyrotoxicosis. How should they be used; for what kind of case should they be reserved? Thiouracil is

obviously an important adjunct in the preoperative preparation of the patient with hyperthyroidism. It is better than iodine and should be used to prepare all patients for operation except those with thyrotoxicosis of mild degree. As the sole, or medical, therapy, it can be used, in spite of its toxic properties, in patients in whom operation is contraindicated for some reason. Careful periodic check should be made of the residual goitre, looking always for a localized area of continued growth or the appearance of enlarged lymph nodes which would suggest spread into the lymphatic system.

A therapeutic dose of radioactive iodine can be freely used in patients of the older age group in whom the life expectancy is less than twenty-five years. It can also properly be used in patients in whom there is a recurrence of hyperthyroidism, a regrowth of goitre and in whom following the first operation the presence of tetany indicated parathyroid damage. It might also be used in such patients when paralysis of a single vocal cord resulted from the operation. Its use is contraindicated, according to my speculation, in younger patients in whom there is no contraindication to operation and in whom life expectancy is greater than twenty years.

In summary, the thyroid is an organ of epithelial origin in which the incidence of carcinoma is not

uncommon. In weighing the merits of any therapy of a goitre, its influence on the development of malignancy must be kept in mind.

Two new and effective methods of treating hyperthyroidism have recently been introduced: thiouracil and radioactive iodine. Thiouracil increases the hyperplasia of the disease and leaves a goitre as a legacy. Although carcinoma is seldom a sequel of hyperplasia, this residual goitre must be watched. Radioactive iodine destroys the goitre by radiation. From the example of other epithelial tissues which have been heavily irradiated there should be hesitation in the use of this radiation method, it being reserved for special circumstances.

Radioactive iodine in tracer dosage is useful diagnostically in revealing metastases and to check the completeness of the removal of thyroid tissue. It unfortunately does not differentiate between malignant and non-malignant tissue since both may be functioning and the isotope is absorbed by all functioning tissue.

Operation remains the only method of excluding carcinoma. The incidence of carcinoma in lump localized to one part of the thyroid gland of the cases studied at the Massachusetts General Hospital is sufficiently high to warrant prompt operative exploration in all such cases.



## THE USE OF THIOUREA IN THE CONTROL OF HYPERTHYROIDISM

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CERTAIN newly recognized goitrogenic substances which produce hypothyroidism in experimental animals can be used in the treatment of human hyperthyroidism. Thiourea and thiouracil were the first of these compounds to be used in human subjects.<sup>2</sup> The clinical use of thiourea was soon abandoned, however, because of dermatitis, halitosis, anorexia, and vomiting. Thiouracil, on the other hand, produced no such untoward results, and was a more potent goitrogen than thiourea in normal rats.<sup>1</sup> Consequently thiouracil has been widely used in this country in the treatment of thyroid overactivity. It has proved to be an effective, but unfortunately a dangerous, antithyroid agent. In some 5,000 patients it has produced leucopenia in about 5 per cent and agranulocytosis in 1 per cent.<sup>14</sup> The latter complication has occasionally been fatal.

This fact has restricted the usefulness of thiouracil in the treatment of hyperthyroidism, and has led to a search for more innocuous compounds of similar therapeutic potency. Many complex derivatives of thiouracil such as methyl thiourea and thiobarbital also exhibit the dangerous features of thiouracil itself<sup>4</sup> although recently it has been claimed that the propyl derivative is less toxic.<sup>5</sup> It was reasonable, therefore, to re-examine the clinical utility of the parent compound, thiourea, which possesses the simplest chemical formula, in the hope that it might prove less toxic than thouracil. To avoid the undesirable gastrointestinal symptoms produced by the 1.0 to 3.0 gram doses of thiourea originally employed, smaller amounts were used. It was soon discovered that thiourea is at least as efficient as

thiouracil in the control of human hyperthyroidism, whatever is their relative goitrogenic potency in the normal rat. At the level of dosage used, it also seems less liable to produce agranulocytosis.

## TREATMENT OF HYPERTHYROIDISM WITH THIOUREA

During the past two years we have treated more than 100 hyperthyroid patients with thiourea. The original diagnosis of hyperthyroidism was based upon an elevated concentration of precipitable iodine in serum, associated with symptoms and signs of thyroid overactivity, and usually accompanied by an increased basal metabolic rate. The group included patients with diffuse and nodular goiters, both primary and recurrent. The ages of the patients ranged from fourteen to seventy-seven years. Females have predominated, about eight to one. Exophthalmos was present in about one-quarter of the subjects. Twenty-six of the patients had received iodine solution for periods of two weeks to one year before institution of thiourea therapy.

A remission in the hyperthyroidism appeared in more than 95 per cent of all patients while receiving thiourea in doses smaller than those recommended for treatment with thiouracil. For example, of thirty-four patients treated with 0.210 to 0.280 gram of thiourea daily, thirty-three became euthyroid in one to twelve weeks. This is approximately one-third of the daily dosage of thiouracil usually employed.<sup>15,16</sup> It is clear, therefore, that the more pronounced goitrogenic effect of thiouracil in euthyroid rats does not carry over to the treatment of human hyperthyroid subjects. Furthermore, it is evident

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*Based upon material presented by Dr. T. S. Danowski before the Clinical Congress of the Connecticut State Medical Society, September 10, 1946*

that the unpleasant gastrointestinal effects of thiourea appear only with excessive and probably unnecessarily large amounts of the drug. The mild symptoms which occasionally developed at the level of dosage employed in our series could readily be eliminated by a reduction or redistribution of the daily dose.

Administration of thiourea in these amounts to patients with hyperthyroidism produced the characteristic manifestations of decreased thyroid function. The serum precipitable iodine, the level of which corresponds to that of circulating thyroid hormone,<sup>9</sup> declined to euthyroid concentrations (4 to 8 gamma per cent). The average length of time necessary for the serum precipitable iodine to reach normal levels was four to six weeks, although the interval might be as short as one week or as long as twenty weeks. This decline of the serum precipitable iodine was accompanied or followed by a fall in the basal metabolic rate and by clinical improvement. Nervousness disappeared, the pulse rate dropped, and body weight increased.

Prolonged ingestion of thiourea in the dosage employed to produce the initial remission often resulted in hypothyroidism, which might become clinically severe.<sup>6</sup> Concentrations of precipitable iodine in serum fell below 3.0 gamma per cent, basal metabolic rate usually became subnormal, and serum cholesterol rose. Euthyroid status could be restored either by the daily ingestion of 0.03 to 0.09 gram of desiccated thyroid, U.S.P., or by reduction in the daily dosage of thiourea.<sup>6,7</sup>

#### ROLE OF IODINE MEDICATION IN THE TREATMENT OF HYPERTHYROIDISM

The mitigating effects of iodine medication in thyroid overactivity have been universally recognized.<sup>10</sup> Complete control, however, of the hyperthyroid state on this medication alone is the exception rather than the rule.<sup>8,13</sup> It has also been held,<sup>12</sup> though probably erroneously,<sup>10</sup> that iodine medication loses part of its efficacy with prolonged administration. This tendency to look askance upon the prolonged use of iodine in hyperthyroid subjects has been carried over into the new field of anti-thyroid drugs. It has been repeatedly stated that prior or simultaneous use of iodine medication renders patients with hyperthyroidism partially refractory to thiouracil and to thiourea.<sup>3,16</sup> Controlled clinical observations indicate clearly, however, that this is not a fact.

We have found that the prior use of iodine solu-

tion for periods as long as one year before starting thiourea therapy in no wise interferes with the efficacy of the thiourea.<sup>6,7</sup> On the contrary, the prior or simultaneous use of iodine medication in hyperthyroid patients enhances the beneficial effect obtained with thiourea. The response is more rapid and may be obtained with a smaller dosage when the drugs are employed in combination than is the case when thiourea is given alone.<sup>7</sup> Furthermore, the iodine medication continues to exert a favorable effect even during the remission, since withdrawal of the iodine from patients maintained on thiourea is followed by an exacerbation of hyperthyroidism in some of the subjects. The disease can then again be brought under control by reinstitution of iodine therapy without alteration in the dosage of thiourea.<sup>7</sup> The work of Rawson and his associates<sup>11</sup> has provided independent experimental confirmation of this clinical fact and suggests an explanation. Thiouracil therapy reduces the excessive output of thyroid hormone by the thyroid gland in hyperthyroidism by preventing its original synthesis. At the same time thiouracil therapy intensifies the initial anatomical hyperplasia. Rawson found that administration of iodine at this point, while thiouracil is continued, reduces the hyperplasia without breaking the blockade of synthesis and without increasing the storage of iodine in the gland. This was interpreted as evidence that the effect of iodine medication in reducing the thyroid hyperplasia is independent of its other usual effect of increasing the storage of iodine in the gland. It was conjectured that the reduction in hyperplasia could be attributed to inhibition of the stimulating action of pituitary thyrotropic hormone. Hence the simultaneous use of iodine with thiourea results in an attack upon hyperthyroidism at two different sites: the point at which the thyroid hormone is elaborated and the point at which thyrotropic hormone acts. Additive effects in hyperthyroidism would therefore be expected. Suspicion of combined therapy with iodine and with thio-derivatives has stemmed in part from the experimental observation that a low dietary intake of iodine favors the goitrogenic activity of thiouracil in the normal rat.<sup>3</sup> Attempts to apply conclusions drawn from such experiments to the treatment of human hyperthyroidism neglect completely the fact that iodine is without measurable metabolic effect in normal subjects, although it markedly inhibits thyroid activity in hyperthyroidism.

This additive effect in all probability accounts for the satisfactory results obtained with very small



amounts of thiourea. We have observed remissions in hyperthyroidism in more than 80 per cent of patients treated with 0.075 to 0.025 gram of the drug together with iodine solution.

#### MODE OF ACTION OF THIOUREA AND SIMILAR COMPOUNDS

Thiourea blocks the synthesis of thyroid hormone in the gland. The depletion of the hormone already stored in the gland occurs at a normal rate. When this supply is exhausted, the serum precipitable iodine falls and the metabolic effects of an insufficiency of thyroid hormone appear. The pituitary gland responds by an increased secretion of thyrotropic hormone which in turn causes the thyroid gland to become hyperplastic. The hypothyroidism and glandular hyperplasia can be prevented or corrected by giving a sufficient amount of exogenous thyroid, or by reducing the dose of thiourea. Iodine medication will reduce hyperplasia but will not benefit the hypothyroidism.

#### PRINCIPLES FOLLOWED IN THE USE OF THIOUREA IN HYPERTHYROIDISM

We are now giving 0.025 gram of thiourea *per os* at eight hour intervals, for a total daily dose of 0.075 together with fifteen drops of strong iodine solution, U.S.P., to patients with hyperthyroidism.\* A complete history and physical examination are obtained prior to treatment together with urinalysis, total and differential blood count, basal metabolic rate and serum precipitable iodine. During the first eight weeks blood leucocyte and differential count are repeated at intervals of one week or less. At four to six weeks, and at similar intervals thereafter the basal metabolic rate and serum precipitable iodine are measured, in addition to further blood counts. When the hyperthyroidism has reached a state of remission the daily dose of thiourea is reduced to 0.050 or 0.025 gram, or less. The iodine solution is continued. In any patient in whom an exacerbation would be dangerous, this regime should be continued indefinitely. It appears to be quite safe, and avoids the tendency to exacerbation of hyperthyroidism which follows withdrawal of therapy.<sup>8,15</sup> Hyperthyroidism has recurred after more than two years of treatment with thiourea.

In the few patients in whom the 0.075 gram dose appears to be ineffective it may be necessary after fifteen or twenty weeks of treatment to increase

the amount taken daily. This should be accomplished by raising the frequency rather than the size of the dose.

The periodic determination of either the serum precipitable iodine or the basal metabolic rate is indispensable for adequate control of the patient. In this way the appearance of either hypothyroidism or of a recurrence can be detected and corrected. These two measurements are, unfortunately, not entirely interchangeable. Although the serum precipitable iodine is a more sensitive index of thyroid function than is the basal metabolic rate, it is both expensive and generally unavailable to the practitioner. The basal metabolic rate does, however, yield information of sufficient clinical value to control the course of treatment in most cases. It must be recognized that in general changes in the basal metabolic rate lag behind those in the serum precipitable iodine by an interval of two to four weeks. Since, however, the basal metabolic rate occasionally fails to reflect closely changes in the thyroid status, it is always necessary to consider the general clinical course of the patient. Changes in body weight and in pulse rate are valuable signs. It is particularly important to recall the fact that mild hypothyroidism need not necessarily depress the basal metabolic rate below normal limits.<sup>17,18</sup>

#### THE FUTURE OF THIOUREA THERAPY IN THE TREATMENT OF HYPERTHYROIDISM

So far the program outlined above has proven to be safe. There have been only two toxic reactions, both consisting of drug fever, with the large doses used initially. Drug fever has not been observed with the smaller doses. Urinalyses and blood counts have remained within normal limits. Leucopenia and agranulocytosis have been absent. Skin eruptions have not developed. There have been no gastrointestinal symptoms with the smaller doses now in use.

This series is obviously small and requires extensive expansion before the true incidence of toxic reactions can be calculated. Nonetheless, it promises to yield a lower rate of toxic reactions than has been encountered with thiouracil. Further clinical trial is warranted under careful observation.

There will always be a significant number of patients with severe heart disease or other major illnesses in whom surgery would be dangerous. For these patients there is no choice other than the use of antithyroid drugs. The use of thiourea means, for practical purposes, that an indefinite treatment and follow up period will often be necessary.

\*Larger amounts, up to 0.210 gram daily, are used in patients who have complicating illness or who fail to respond promptly.

For most patients thyroid surgery offers an alternative solution. Many patients and physicians are attracted to surgery by its greater decisiveness, since in the majority of cases careful thyroid surgery is followed by permanent cure.<sup>10</sup> It is not, however, possible to dispense with frequent follow-up examinations for months and years following subtotal thyroidectomy if the best results are to be assured. Against the desirability of surgical treatment must be weighed the considerable incidence of immediate and eventual complications. Even under the best of circumstances there is an immediate operative risk, and there are bound to be a few cases of vocal paralysis and of hypoparathyroidism. Most serious of all, it seems impossible to devise an operation which will reduce the incidence of recurrences to a low level without simultaneously increasing the frequency of hypothyroidism; and *vice versa*.<sup>18</sup> The practitioner must weigh all these considerations in order to decide upon the particular form of treatment best suited to the individual patient.

#### CONCLUSIONS

The treatment of hyperthyroidism with iodine and small doses of thiourea simultaneously is described and the results in over one hundred cases are discussed.

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## HEALTH — THE FIRST OBJECTIVE OF EDUCATION

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IN 1918 a committee of school administrators met to list the objectives of secondary education. As a result of this meeting the seven cardinal principles of education were produced. The first of these, *health*, along with the other principles, has since served as a guide in the field of education. In this paper I am especially concerned with the health objective. To make this objective functional, there are many problems which need attention. One of these can be illustrated by quoting from Chapman and Counts as follows: "Greeting his pupils the

master asked, 'What should you learn of me?' and the reply came—

"How shall we care for our bodies?"

"How shall we rear our children?"

"How shall we work together?"

"How shall we live with our fellow men?"

"How shall we play?"

"For what end shall we live?"

"And the teacher pondered these words and sorrow was in his heart for his own learning touched not these things."

This quotation illustrates the need for adequate and more effective teacher training especially in the health area. Before teachers will be adequately

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rained to meet the health objective, they should know:

1. Why all children should have a physical examination (medical and dental) (a) on or before admission to school and at regular intervals thereafter as deemed advisable; (b) on readmission to school following any major illness; (c) on teacher referral when pupil's appearance, performance, or routine screening test records suggest failing health or defects.

2. Why the teacher and parent should attend the examination of younger children.

3. How to secure the cooperation of the medical and dental professions to assure examinations that are thorough and educationally sound.

4. How to conduct daily inspection of all pupils and how to recognize signs of deviation from normal health status.

5. How to conduct routine screening tests to discover defects of vision, hearing, and failure to grow.

6. What information to teach in instruction courses to aid in the follow-up of medical and dental examinations to assure (a) the correction of correctible defects and the prevention of preventable conditions; (b) the assignment of pupils to modified activity programs where this is needed.

7. The use of a cumulative record blank designed to follow the child throughout its school life and also how to record and read the results of physical examinations, screening tests, and physical fitness inventories, dates of major illnesses, dental visits, immunizations and corrective measures taken.

8. How to organize health instruction on a specific school level and to plan for healthful living throughout the school experience.

9. Health knowledge sufficient and accurate enough to teach adequately the information needed and to develop the habits and attitudes essential to effective home, school, and community life.

10. How to plan and conduct at least 40 minutes daily, physical education activities suited to the grade level involved.

11. How to classify pupils for physical education activities on the secondary level with respect to age, sex, grade, ability or special needs.

12. Where to look for expert supervision and direction at local, State, and national levels.

13. The importance of (a) the extension of inventory and correction of defects into the pre-school years; (b) the insuring of sound mental health; (c) the improvement of child nutrition through the provision of adequate school lunches;

(d) the provision of camping and other extended school services contributing to health; (e) the systematic cooperation with all community health efforts.\*

These are only a few of the items that teachers need to know. However, there is also a need for knowledge of the health and fitness needs of the school age child. An inter-governmental committee has recently drawn up a statement of the health needs of the school age child. Briefly stated they are:

1. Safe, sanitary, healthful school environment.

2. Teachers who are equipped by training, temperament, and health to give not only specific instruction but who can also help children to mature emotionally.

3. Protection from infections and conditions which interfere with proper growth and development.

4. An opportunity to realize their potentialities of growth and development.

5. To learn how to live healthfully.

This statement of needs should cause us to realize that schools do not have the sole responsibility for the health of school children.

The health department is the center of the public health activities. The average citizen looks to the health department for a safe water supply, adequate sewage disposal, protection from epidemics and other common health hazards. More recently he is learning to avail himself of the educational service in personal and public health provided by some public health departments. Police methods have given way to educational methods as alert and progressive health officials have raised the standards of public health by teaching the principles of healthful community living.

In the newer fields of public health such as nutrition, infant and maternal welfare, mental and social hygiene, the method of attack is chiefly *educational*. An intelligent, well informed public is more sympathetic toward and cooperative with public and school health activities.

Many of the health departments of the country have health education programs but few of these programs take into consideration the advantages and the possibilities of the school program in health education. The schools include about one-fifth of the population of the country and school days represent the period when attitudes, knowledges, and

\*U. S. Office of Education, *Education for Victory*. January 3, 1945.

habits are being acquired in health as well as in other lines.

It is true that health practices of children depend largely upon what their parents permit them to do, but it is also true that the parents permit or encourage that which the child wants if it is reasonable and within their financial ability.

The health department knows the health problems of the State, the health facts and the health resources. It is in a position to make a fundamental contribution to any health education program; however, health departments may lack personnel trained in educational methods and techniques. The schools are the only social agency employing trained educators in the ratio of one to every forty individuals in the population group reached.

During the past few decades the schools have placed more and more emphasis upon individual instruction, upon determining the needs of the child and upon shaping the curriculum to meet those needs. This trend in education makes it inevitable that the schools should be interested in the health of the child. The need is obvious and its relationship to school progress, intimate.

Modern education does not wait until the child comes to school to begin its program. Through parent-teacher associations and other groups, it endeavors to prepare the child for school physically and socially. Modern school systems are now extending their activities to include various forms of adult education.

The modern public school has an important role in community health education. A study of the school program should reveal that all schools cannot satisfactorily provide: health instruction (including health guidance), health examinations, physical education adjusted to pupil needs, communicable disease control, promotion of mental health, provision of healthful environment and regimen, health supervision of teachers and employees; without the aid and guidance of public health departments. All schools and State departments of education are struggling with these problems. Some of these departments have attempted to solve them by appointing a Director of Health and Physical Education. Usually this is not entirely satisfactory because this person does not have access to public health information and resources nor the understanding and cooperation of the public health authorities. On the other hand, the public health authorities do not have an entree into the schools nor, in many instances, a

knowledge of school administration, procedure or educational methods and techniques.

This overlapping responsibility and resources to meet the health needs of the school age child makes imperative cooperation and coordination of the health department and education department programs. There must be a working together—neither can entirely meet these needs working alone. It is essential that the resources of both education and health be utilized, because an efficient, effective health program for all children of a community will result only when:

1. The public departments of health and of education as well as specialized personnel within each department agree to the principle of integration of school health programs with the health program of the community and with the educational program of the schools.
2. Each agency and profession respects the contribution of the others.
3. The agencies agree to an administrative plan which will promote the most efficient and cooperative direction of the several phases of the program and the supervision of the several types of professional workers.
4. The professional workers of each agency are permitted to perform services in their professional fields for the best interest of all children.
5. Sufficient funds become available to carry out the program.

The Interagency Committee which I previously mentioned as responsible for the statement of the health needs of the school age child felt that the agencies on the Federal level should set an example by cooperating and as a result prepared the following specific statement which has been presented to the administrators of the agencies named.

The U. S. Office of Education, the Children's Bureau, and the U. S. Public Health Service should form a coordinating committee to plan jointly the activities of the Federal Government in school health, including the integration of the existing programs, the planning for any extension of these programs, the formulation of over-all policies, and the establishment of regulations governing the administration of any funds that may be made available.

This committee felt that they should not only set the example but that they should offer suggestions which would aid cooperation on the State and local level. The following suggestions were made:



1. Committees comparable to the coordinating committee on the Federal level should be established at the State and local levels between Departments of Public Education and Health. These committees may include representatives from professional educational institutions and other agencies and professional groups concerned with the health of the school child.

2. In the departments responsible for health instruction, physical education, and health services there should be qualified professional personnel such as physicians, nurses, and educators all of whom have been trained in school health.

3. A comprehensive program to meet the health needs of school children in any State should provide for:

a. Development or extension of programs in teacher-training institutions to prepare administrators and teachers so that they can participate effectively in the school health program.

b. Appropriate pre-service and in-service education for school health administrators, teachers, nurses, physicians, dentists, and other specialized health personnel serving the schools.

c. Adequate time allotment for health instruction and physical education of children and for their participation in solving individual and community health problems.

d. Planning for construction and inspection of the school plant and its sanitary provisions and planned program to insure and utilize a safe and sanitary school environment including transportation.

e. Thorough school medical examinations including necessary immunization and laboratory procedures.

f. Special testing programs and treatment as needed for abnormalities such as those of vision, hearing and speech.

g. Cumulative health records.

h. A school lunch program developed as part of the total educational program.

i. Dental care.

j. Mental hygiene.

k. Care for children with crippling diseases, especially rheumatic fever.

l. Demonstration areas for the development of improved techniques to meet the needs with respect to the school health programs of the individual States.

m. Organized program of parent participation and education.

n. Health services for school personnel.

You may say that there is nothing new in these suggestions and that this is needless repetition. However, there needs to be repetition since reports made to the Office of Education from 992 schools in 1943-1944 show that only 55 per cent of boys in the junior and senior year and 46.7 per cent of girls in the junior and senior years were enrolled in physical education classes, while but 20 per cent of the boys and girls in the junior and senior years were enrolled in health education.

There are many other indications that we are not utilizing our resources and that neither health departments nor education departments working alone have been able to do all that needs to be done. The fact that public health and public education programs overlap should not be seen as waste but as an occasion for team work. Inter-professional conflict should not be seen as hostility but as proximity that in itself has value.

## PENICILLIN IN THE TREATMENT OF TETANUS: CASE REPORT

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**T**ETANUS is a highly fatal disease, the treatment of which in a well established case by no means offers a 100 per cent chance of recovery.<sup>1,2</sup> The most recent advance in the treatment of tetanus has been the use of penicillin together with the usual dosage of tetanus antitoxin.<sup>3,4,5</sup> The use of active immunization as practiced universally in our armed

forces, has undoubtedly done a great deal to decrease the incidence of this disease. However, in the year 1944 there were 615 reported civilian deaths in the United States due to tetanus infection.<sup>6</sup> For these reasons, and inasmuch as the value of penicillin in tetanus has not been adequately determined on a statistical basis, the following case is reported.

The patient, W. S. a 30 year old white single female was admitted to the hospital with a history of sudden excruciating pain in the lower thoracic and lumbar region of the back. The pain was intermittent, occurring every 3 to 4 minutes. Close questioning revealed that the patient had instrumented herself vaginally in an endeavor to terminate a suspected pregnancy, 7 days before admission.

Physical examination on admission revealed a well developed, well nourished female in acute distress, perspiring profusely, extremely apprehensive and complaining of intermittent pain in the thoraco-lumbar region of the back. The facial muscles showed generalized rigidity and the patient was able to open her mouth only approximately one half an inch. The abdominal muscles were board-like throughout with some distention but without pain or evidence of acute abdomen. The musculature of the extremities was hyper-tonic and the reflexes were exaggerated. There was partially sustained clonus of the patellar and ankle reflexes. The neck was rigid. Babzinski reflexes were negative bilaterally. Temperature on admission was 101 degrees rectally, respirations 20, pulse 100 and blood pressure 140/80.

Laboratory studies on admission showed rbc. 3.7; hgb. 11.5 grams (74 per cent); wbc. 6,500; neutrophils 56 per cent; non-segmented 6 per cent; eosinophiles 2 per cent; lymphocytes 34 per cent; monocytes 2 per cent. Urine was cloudy, alkaline, sp.gr. 1.015; albumin negative; sugar negative; occasional white cell per high power field. BSR was 30 mm. per hour; NPN 22; serology negative. Spinal fluid initial pressure 180, final pressure 150; dynamics normal; 8 cc. of clear, colorless fluid showed cell count 3 rbc; total protein 24; sugar 47 and chlorides 680; sugar 108; culture negative; colloidal gold normal. Subsequent laboratory studies during the course of her illness are as follows. On the fourth hospital day a repeat lumbar puncture was normal. On the fifth hospital day serum calcium was 7.8 mgms per cent and on the seventeenth hospital day 10.1 mgms per cent. On the eleventh hospital day BSR was 38; on the sixteenth hospital day NPN was 133; total protein 5.1; albumin 3.8; globulin 1.3; serum amylase 46 mgms. per 100 cc. and on the seventeenth hospital day 39 mgms. per 100 cc. On the twenty-ninth hospital day BSR was still elevated at 50 mm. per hour. On the thirty-third hospital day vaginal and cervical smears showed many gram negative and gram positive bacilli and occasional gram positive cocci. Culture and smear were negative for gonococci, on the thirty-fourth hospital day BSR dropped to 36.

#### COURSE IN THE HOSPITAL

The diagnosis on admission was not apparent and the patient received only supportive treatment for the first three days. During this time she complained bitterly of sudden seizures of back pain and of an inability to swallow food. The temperature on admission was 101 degrees rectally and fluctuated between 100 and 102.5 degrees daily until three days before discharge when it became normal. The pulse, usually elevated in tetanus, was as high as 140 and gradually fell to normal at the time of discharge.

On the second hospital day, a lumbar puncture was done with great difficulty and was negative. On the fourth hospital day another puncture was done and was likewise negative. At this time, penicillin in a daily dose of 160,000 units, 20,000 units q.3.h. intramuscularly was started on an empirical

basis. This was continued for twelve days in the same dosage for a total of almost 2,000,000 units. The patient showed very little improvement during this time and at the end of 12 days she was still having tetanic spasms as often as every five minutes and particularly in the morning when nursing care was being administered. The spasms were very painful and caused considerable perspiration and anxiety. A typical spasm produced a severe opisthotonus with hyperextension of the neck, back, arms and legs. There was marked trismus of the facial muscles producing the so called sardonic smile. The leg muscles were markedly spastic. There was severe continuously sustained hyperextension of both legs. The feet were inverted and the large toes crossed outwardly towards the little toe bilaterally. Before her illness her feet and musculature in general were normal.

On the fifteenth hospital day after having received almost 2,000,000 units of penicillin over a period of twelve days without other specific therapy, 50,000 units of tetanus antitoxin were given intramuscularly on the first day and 100,000, 80,000 and 40,000 on consecutive subsequent days for a total dosage of 350,000 units at which time the local supply became exhausted. On the third day of this administration after a total dosage of 230,000 units, the patient felt and appeared much improved. She was able to turn about on her side in bed unaided for the first time since admission. She was able for the first time to flex her knee to an angle of about 90 degrees. At the end of the fifth day of administration after the above mentioned total of 350,000 units she was able to flex both knees past 90 degrees. She continued, however, to have tetanic muscular contractions chiefly in the morning but much less frequently and severely than before antitoxin was given.

Antitoxin was discontinued at this point for 96 hours because of no immediately available supply and during this time the patient's condition remained about the same. She was still having painful spasms at the rate of four to five a day. She was now, however, able to chew her food for the first time. The abdomen which had been rigid during the first two weeks of her admission became much softer.

On the twenty-third hospital day, at the end of this 96 hour period antitoxin was resumed in order to maintain its maximum effect, although it was realized at the time that at least without penicillin the greatest value of antitoxin is derived from its administration in the early hours of the disease.<sup>2</sup> Over a seven day period 560,000 additional units of antitoxin were given. Two days after the last dose all tetanic spasms disappeared. During this period the patient was able to sit up in a chair for the first time and at the end was able to walk about despite the fact that the leg muscles were still spastic. No further tetanus antitoxin was given. Penicillin which had been administered continuously since admission in a daily dosage of 160,000 units was likewise discontinued at this time after a total dosage of 3.8 million units.

During the first four weeks of her illness a careful pelvic examination was impossible because of the above described muscular spasticity, particularly of the lower extremities. This was done on the thirty-third hospital day and revealed a red, healed abrasion along the outer edge of the cervix consistent with a puncture wound. Tetanus bacilli were not identified from this site.



Following discharge, the patient was seen in the office on three separate occasions and a complete neuromuscular examination was negative. Recovery from her infection was apparently complete. At no time did the patient develop evidence of serum sickness despite a total dosage of almost 1,000,000 (910,000) units of tetanus antitoxin.

#### SUMMARY AND COMMENT

A case of tetanus is presented in which initially, penicillin alone without tetanus antitoxin was given for over a period of twelve days continuously for a total dosage of almost 2,000,000 units. During this period there was very little subjective or objective improvement in the patient's condition. In general her muscular spasticity was somewhat more severe although the tetanic seizures were no more numerous than at the onset of the infection.

At the end of this twelve day period, tetanus antitoxin in addition to the same daily dosage of penicillin was administered and there was a prompt marked improvement in the patient's condition as described in the case summary. After 350,000 units of tetanus antitoxin were given the local supply became exhausted and during the subsequent 96 hour period the patient's condition grew slightly worse. Tetanus antitoxin was resumed for seven consecutive days for an additional dosage of 560,000 units and an overall dosage of 910,000 units. At this point both penicillin and antitoxin were discontinued and the patient was discharged essentially well except for residual muscular stiffness which completely disappeared in follow-up examinations.

Although certainly no conclusion can be drawn from one case, three points are suggested. First it

appears that penicillin, when used alone without tetanus antitoxin, is largely ineffective, in the usual sense, in the treatment of tetanus; that is, it does not produce the usual dramatic response that occurs in penicillin susceptible infections. Secondly, it may be, however, that penicillin alone does have some suppressive action in the treatment of tetanus inasmuch as the condition of this patient remained unchanged rather than becoming progressively worse over a 12 day period during which time penicillin alone was administered. Thirdly, it appears that, provided penicillin is used continuously, tetanus antitoxin which is usually effective only early in the course of the disease, is effective later in the disease as well.

More cases of penicillin treated tetanus must be reported before the exact therapeutic status of penicillin in tetanus can be determined.

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### ADDRESS BY THE PRESIDENT

COLE B. GIBSON, M.D.

**P**RECEDENT REQUIRES that at the meetings of the House of Delegates the President shall report upon the activities of the Society in the interim since the previous meeting. In addition, it is customary for him to comment upon pertinent happenings outside the state at the national level.

Since other officers and chairmen of important committees also are requested to submit reports at this time, some matters may receive repetitious discussion. To avoid this as much as possible, this report will touch upon highlights, leaving to others

the presentation of essential details. Where repetition does occur, it is hoped that it will serve as emphasis and will provide opportunity for expression of several viewpoints on important matters.

I am pleased to report, and I suspect that most of you are aware, that the officers and many of its members have been diligent in their activities on behalf of the affairs of the Society. It has been a stimulating experience to observe at close range a number of men who have given so freely of their time and energy. In their devotion these men have

sacrificed themselves, their families, their comforts and their practices in order to serve the Society and Medicine.

One looks back for a period somewhat under a decade and visualizes a remarkable growth of the Society. In its importance to good medicine, in its service to its members, in its development of functioning committees that have done so much to improve medicine in divers fields, in its outstanding periodical, in its contributions to the broader activities of American medicine, and in its additions to the intelligence of the American Medical Association, the Connecticut State Medical Society has grown to a stature in which its membership takes pride and to which is given the high regard of other state societies.

It must be clear that this happy situation has come about only because we have been blessed with men of vision and ability, coupled with a willingness to work. There are many, many more in the Society with vision and ability. To sustain its life, to continue its growth and progress, the Society needs the active participation of these men in its affairs. It is the duty of each of us to provide the stimulation necessary to produce in these men the desire to serve and work for the best interests of medicine through the State Medical Society.

In this connection, mention should be made here of the work of several committees. To the Committee on Veterans Affairs, several Veteran officers of World War II were appointed. These men immediately attacked the problem with spirit and intelligence. They moved rapidly, presented a comprehensive report and recommendations to the House of Delegates in May. Following this, they continued in active contact with the Veterans Administration and have now negotiated an agreement whereby the care of veterans with service connected disabilities can be handled with satisfaction to the veterans and their own physicians. This has been a real contribution.

The Committee on Industrial Health has done an outstanding job. Besides bringing together physicians engaged in industrial health work for consideration of mutual problems, this Committee has established between the manufacturing interests of the state and Connecticut medicine a basis for mutual understanding, respect, and cooperation that never before existed to such a degree. This development contributed in some part to a decision to establish an Institute of Occupational Health at the Yale Uni-

versity School of Medicine. The future of industrial medicine holds much promise. Not only is the Committee fully aware of this, but it is assiduously applying itself to the proposition that the promise shall be fulfilled.

The Committee on Prepaid Medical Care has expended more man hours than I personally should like to compute. These men have studied, examined, reviewed, digested and assayed practically every conceivable plan devised for providing financial means to meet the cost of medical care. They have weighed service plan against indemnity plan. They conceived an insurance plan that might be conducted by the State Society. They spent long hours poring over the provisions of policies issued by commercial insurance carriers and spent much time in deep discussion with keen representatives of these companies. They visited other states to inquire into the workings of prepayment plans there. Assembling and digesting, and evaluating this information called for profound thought and sound judgment. The report that will be made today will serve to indicate, I believe, that the Committee has been careful, realistic, and perceptive in the selection of a method that offers in the light of experience and present knowledge the most satisfactory plan for patient and physician that is now available.

Even though a plan is now offered this Committee feels that it should continue to function for a further period. This will provide opportunity for constant scrutiny of the workings of the plan, and a method for checking its efficiency. Also, the Committee will initiate recommendations for such future modifications as may be indicated.

For this and for its able service and arduous labor, the Committee deserves the unstinted gratitude of the Society.

I should like to discuss the activities of other committees, other groups and other individuals but I regret that time will not permit. However, you will hear from several of these today, and then I believe you will agree that your Society is receiving the benefits of the efforts of a group of able men who are alert, forward looking and imbued with the desire to improve and enrich Connecticut medicine.

One of these men is our Executive Secretary, Creighton Barker. Again looking back over almost a decade I think that we can happily agree that the upsurge in the importance of our Society coincides with his tenure in office. It would be impossible to enumerate his contributions to the progress of the



Society. By the sum total of his wisdom, his resourcefulness, and his earnest attention to the welfare of Connecticut medicine he has played a major part in elevating the Connecticut State Medical Society to a place of high regard, both at home and abroad. To him as many of us know, this has been a labor of love. It should be said, also, that the laborer is worthy of his hire.

The contract between the Connecticut State Medical Society and Dr. Creighton Barker for seven years expires on December 31, 1946, with option to renew for three years under the same conditions. I am privileged to report that a new contract has been signed with Dr. Barker, effective January 1, 1947, with increased remuneration, for a period of three years, with option to renew for five years thereafter. I am certain that we all hope that our present Executive Secretary will be with us for many years to come.

At this point I should like to pay my respects to two gentlemen who have done and continue to do so much for our Society. It has been my pleasant privilege to sit in the Council of the State Medical Society with two Chairmen of that Council. While I was President elect, Dr. Miller was Chairman until the time when he and Connecticut were honored by his election as Trustee of the American Medical Association. Following this, Dr. Murdock was elected Chairman. These two men followed in the footsteps of some of Connecticut's most able and distinguished physicians. I am very certain that their predecessors were very proud to have two such men in the succession. For us as physicians, for our Society and for American medicine, these men have labored well; their works have been good, and we congratulate ourselves that Connecticut has such as these.

The CONNECTICUT STATE MEDICAL JOURNAL continues to stand at the top in comparison with other State Society *Journals*. Dr. Weld, the Editor in Chief, who has been nationally recognized by the Conference of Journal Editors, and Dr. Thoms, the Literary Editor, combine to produce a publication that is a very real asset to Connecticut medicine. The selection of scientific articles is excellent. The editorials are timely and meaty. News articles relating to happenings at home or to important events in the national and international fields of medicine are given good coverage as are the reports of committees and specialized activities. Truly, the member of the Society who fails to read his JOURNAL

thoroughly is not in tune with Connecticut medicine and is not getting out of the State Society all that he should.

The development of the Woman's Auxiliary is a matter for which we should be mightily gratified. It was not possible to foretell how valuable such an organization might be until it was actually underway. There was no means of determining whether here in Connecticut there was interest in or need for this type of what some envisioned as a purely social project. It is significant that the organization was accomplished in leaps and bounds. It is heartening to know that with excellent leadership the wives of physicians have amalgamated themselves into an earnest and enthusiastic congregation that can wield potent influence on public opinion. Situated as they are, these wives have first hand knowledge of matters on which the layman is either misinformed or totally ignorant. They have access to avenues through which accurate information can flow. They have the will and desire to correct this misinformation and ignorance, often to the same degree that their husbands have the will and desire to correct physical ills. Certain it is that our Woman's Auxiliary in Connecticut is doing a much needed job in splendid fashion.

The 21st Clinical Congress this year was an unqualified success. The scientific programs had attractions for all, studded as they were with stars, who provided practical answers to the work a day problems of modern medicine. The mechanics of the Congress operated smoothly, and a large attendance once more testified to the worth of this enterprise. Moreover, it gave tangible evidence of the value of the cooperation which exists between the Yale University School of Medicine and the Connecticut State Medical Society.

While it will be reported elsewhere, I can not fail to record here the embarkation of the Society upon a program, long discussed, that should have far reaching effects toward bettering our relationship with those other elements that make up the social fabric. I refer, of course, to the inauguration of a public relations representative in the office of the Executive Secretary. The House of Delegates in May directed this action. As you know, we are happy to have engaged Mr. James Burch for this important position. Progress to date inspires confidence that in the future we may expect developments in this field that will be of inestimable value to medicine in Connecticut.

Our County Associations for the most part are functioning well. I am constrained to say, however, that in certain instances there is a tendency to re-linguish to the State Society the responsibilities for certain functions that might more efficiently be met at the County level. This is particularly true in the matter of scientific assemblies and in the utilization of those resources within the county that are available for information and instruction. In some instances, city medical societies have almost supplanted the County Associations in this field. It should be remembered that the County Medical Association is the primary and important unit for the integration of physicians into a cohesive professional group. The individual physician has the right to expect that his County Association will do more for him beyond the perfunctory. The County Association has the right to expect that its members will not be sterile of interest in its functions. Many of us might be benefitted by re-reading the abstract of Julian Price's article on the County Association which was published in the August 1946 number of our State JOURNAL.

Our Building Fund continues to grow, but not with the rapidity or with the full concurrence that might be desired. The building will be built—make certain of that. It will stand for a long time as a symbol of the unity of purpose of the physicians who compose the State Medical Society. Let no one at a later time regret that he failed to provide some substance to that symbol.

I am glad to report a revival in interest in the Council of the New England State Medical Societies. Three meetings of the Council have been held this year, and the topics discussed indicated the community of interest that exists in our geographical section. There is little doubt that this Council offers a workable means for the exchange of infor-

mation of definite value to medicine in New England. There is, of course, no intent to establish an isolated New England bloc, but it is most helpful to have an opportunity to discuss our sectional problems with our immediate neighbors.

At this time there is little to be said about national legislation as applied to medicine. The Wagner-Murray-Dingell Bill is in limbo. The Taft Bill, we are told, will be superseded by an instrument more carefully fashioned. We have looked at the last election returns and as a result some feel that medicine's legislative troubles are over. I do not count myself among that number. True, at the moment we are not striving to defend ourselves; and true, it would seem that medicine will now be able to get a fair hearing. However, it is certain that medicine must never again permit itself to fall into a defensive position. In the grace of this breathing spell we must now honestly and frankly accept the fact that there are faults and voids in the distribution and costs of medical care. Having done so, we must set about devising and putting into operation our own remedies for these defects. This is no time for complacency. It may well be that medicine is having its last chance at ordering its own existence. Now as never before do we need strength and wisdom not only in our leaders, but in ourselves.

I beg your indulgence for the length of this report. I have omitted much that I should have liked to discuss with you. This has been for me a busy period, and I have visited many places, seen many sights, and met many people. It has been the highest privilege of my life to do these things as your representative, and for this privilege I shall always be grateful. It is my fervent hope that in return I shall have been of some small service to the Connecticut State Medical Society.



# CONNECTICUT STATE MEDICAL JOURNAL

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## EDITORIALS

### A Plan for Prepayment Medical Care

The Report of the Committee on Prepayment Medical Care which appears on page 135 of this issue is must reading for every member of our Society. After wise deliberation on the part of the committee, as a Society we will now share in a definite program of medical care insurance which can be offered to the people of Connecticut. This can be done with every assurance that their needs can be met in a way consistent with the tradition of individual responsibility, which for so long has been a part of our political thinking. We can congratulate ourselves on our good fortune in having a committee whose devotion through many years of study has been so consistent and whose deliberations have been so sound. The conclusion of the committee, as seen in the report, that insurance should be written by insurance companies, will find enthusiastic agreement by those who are familiar with the vicissitudes of many plans which have been operated elsewhere by physicians. It is very likely that in Connecticut, the "insurance" state, there is a unique opportunity at the present time for the medical profession and the insurance industry to lead the way in working out together these important social mechanisms. The plan as at present conceived is simple and ready of understanding; premiums collected as dollars will be paid out in dollars as benefits, and not as guaranteed service, the rock which has wrecked so many ships of fine intention in insurance plans. The intent to broaden benefits to cover medical as well as obstetrical and surgical illness is aimed to make the plan one

of wide popular support. We shall await with great interest the details of the contracts which are to be studied by the committee for, as a professional group, we should be able to assist in increasing the sales, which is so important for success. Dr. Miller and his associates have demonstrated once more the high quality of work which is being done by our Society's committees in general. As long as we continue to demonstrate this fine spirit of unselfishness and devotion to the interests of medical service in our state, we need not be too concerned about our position in public relationships.

### Union Contracts and Medical Care

The United Automobile Workers proposed recently through their president, Walter Reuther, that the union's social security program be financed by a 3 per cent employer contribution based upon the gross annual earnings of each employee. Such a fund would be used to provide benefits in the case of sickness or accidental disability amounting to not less than 50 per cent of average earnings for a maximum of 52 weeks in the case of any one disability. Included also are hospital, medical, surgical and maternity benefits and other compensations in case of total and permanent disability. It is estimated that such a tax would create a yearly fund of 40 millions of dollars. In considering such plans of health and welfare development the *Journal of the American Medical Association* recently suggested that labor "may ask for greater direct participation not only in industrial medical service but in plans

for general medical care. . . . Herein lie many opportunities for constructive medical leadership." Medicine should be sympathetic to all real efforts to improve working and living conditions. Under proper direction such welfare funds will not only do a great deal for the needs of working people but they may pave the way for further extension of voluntary health insurance. In commenting upon this subject of medical care in union contracts *New York Medicine* recently stated, "It may be that the labor unions have been reading the election returns and are despairing of early enactment of compulsory health insurance—a measure which we have always considered should be opposed rather than supported by labor unions, in view of the fact that national compulsory health insurance is obviously only a step toward greater federal control over industrial relations generally. Nevertheless, whatever the extra motivations of the unions in proposing medical security measures as a part of future labor contracts, we believe this movement should have the active interest and support of the medical profession."

### A Responsibility of the County Medical Society

The return to a peacetime economy following a war is marked always by difficult and unsettled times. In our own country, to be added to the many recognized problems dealing with social adjustment is the somewhat overlooked fact that we have had a population increase of 10,000,000 since 1940 and, therefore, more people need more of everything, including medical care. The necessity for a wider distribution of such care is not alone geographical, but must include extension to various economic groups, especially those in the lower income brackets. How this should best be accomplished has been for some time the concern of numerous professional and lay groups. Among the latter are those who, apparently oblivious of the numerous failures of government control in other fields, still find a panacea for an overall program of medical care under such directive. However, if one single thing can be read into the result of the recent election it is that as a people we are tired of the attempts to carry over into a peacetime economy many of the governmental controls which were a part of the war effort. A good deal has been said about a return to the American way of life. This has not been, and probably cannot be defined, but the understand-

ing of most people is that it includes as a primary the individual responsibility of the citizen in an economy based to a very great extent on local and state government. It can be said without question that far the greater part of the medical profession in this country believes that the extension of medical care, if it is to be a sound development, must find its basis for operation on such community and state levels. Therefore, a community wide program of voluntary medical insurance demands the full support of all practicing physicians, for it gives new hope for a satisfactory solution of one of the important problems of today. The success or failure of such development will depend to a large extent upon an understanding and cooperative attitude on the part of the county medical society, which as a local and community unit is responsible for the professional standards and conduct of the physicians who are integral in the organization. This means that the county medical society must survey and use every expedient necessary to meet these new and higher responsibilities. Some of our county societies are now in a good position to accept these challenges, for they are strong and active organizations. However, this position is not to be attained simply by the wishes of the county officers, it must be built up by an understanding and a willingness to cooperate on the part of the individual membership.

### The Cooperative Medical Advertising Bureau

Several of our readers at various times have expressed surprise at the quality as well as the quantity of advertising which appears within the covers of the *JOURNAL* from month to month. The majority of this advertising is secured through the Cooperative Medical Advertising Bureau of the American Medical Association. This is true also of all the State medical journals which are members of the Bureau. Only New York and Illinois do not hold such membership.

About four years ago the editors of many of the State journals realized that there were a large number of widely used and efficacious pharmaceutical products which could not be advertised in the State medical journals since they were not accepted by the Council on Pharmacy and Chemistry of the American Medical Association. The problem was carried directly to headquarters in Chicago and conferences were held with the Board of Trustees and with the Councils, in particular the Council on



Pharmacy and Chemistry. Two results have been achieved. First, the Council on Pharmacy and Chemistry has rewritten its rules; second, the Cooperative Medical Advertising Bureau has been reorganized.

Up till 1946 the Council on Pharmacy and Chemistry had been operating under rules adopted forty-one years ago. The revised rules contain two radical changes. One of these relates to the controversial subject of "protected" names. The Council has decided to withdraw this rule entirely and to admit multiple names, with the important provision that the manufacturer give equal prominence to the common "unprotected" name that is or will be provided. The other change is in the broadening of the Council's attitude toward "advertising to the public," permitting such advertising when it is judged that its dangers are less than its benefits. Instead of the former eleven principles the Council now has adopted seven.

The Cooperative Medical Advertising Bureau was organized in 1913 by the Board of Trustees of the American Medical Association upon a mandate from the House of Delegates. The main purpose of the Bureau as set up was to aid the Council on Pharmacy and Chemistry in its efforts to effect some sort of rationale in therapeutics by securing advertising conforming to the rules of the Council. An advisory committee was selected to act as the agent for the Trustees in operating the Bureau. On this committee for thirty years there was but one State medical journal editor. The Bureau has been reorganized with an advisory committee comprising five State medical journal editors selected by the editors themselves, and in addition three ex-officio members from A.M.A. headquarters. A new director of the Bureau assumed office on January 1, 1946. The business of the Bureau has increased steadily during the past few years until the 1946 total reached approximately \$600,000.

During the years of dissatisfaction and reorganization many of the State medical journals carried advertisements of pharmaceutical products considered ethical but not Council accepted. The CONNECTICUT STATE MEDICAL JOURNAL was one of this group. With the revision of the Council's regulations the State journals holding membership in the Bureau have agreed to return to the former rule that only Council accepted products shall be approved for advertising. This does not apply to certain products of local distribution.

The editor-in-chief of the CONNECTICUT STATE MEDICAL JOURNAL has served as chairman of the advisory committee of the Bureau for the past year. It has been a source of satisfaction to find the Board of Trustees and the Council on Pharmacy and Chemistry receptive to suggestions from the various State medical journal editors. Out of all this should come an improvement in the publications of the State medical societies. If we can offer to our advertisers an excellent journal in every State, one which shows painstaking care and a maximum of thought, the success of the Cooperative Medical Advertising Bureau will be that much more enhanced and the work of the advisory committee made lighter. It must not be expected that our all time high in State journal advertising will continue without an effort on the part of each editor to supply in return a product worth every nickel our advertisers invest in us.

### The American Red Cross Carries On

To carry on its postwar activities and to expand its relief, health, and welfare work at home and overseas, the American Red Cross on March 1 will launch its 1947 fund campaign. Upon the generosity of the American people depends the success of this mammoth humanitarian effort.

In supporting the American Red Cross, the American people are helping not only members of the armed forces and veterans. They are also providing warm clothing and milk for children and medicines for the sick in battle-swept lands; they are helping their fellow countrymen in disaster ridden communities; they are helping provide nutrition courses for homemakers on limited budgets all over America; they are making possible first aid, water safety, and accident prevention courses for men, women, and children; they are contributing to training in home nursing and mother and baby care; they are helping roll surgical dressings made by volunteers for service and civilian hospitals; they are helping pack Junior Red Cross gift boxes and medical chests for needy boys and girls, innocent victims of war overseas.

Among the most heartbreaking victims are children in European mountain areas who were blinded by exploding mines in their peaceful sheep pastures. Their gratitude for Junior Red Cross gifts and for chapter produced clothing inspires greater giving from the more fortunate people of this country.

Today more than one-fourth of the current budget has been allotted to overseas services for the armed forces alone to combat the boredom of occupation troops and give them constructive leisure time opportunities; another large percentage will be allotted for work with veterans.

Money is necessary to carry on this work, but who can estimate the money value of friendly service to teen-age boys in a foreign country or to seasoned veterans who may be equally homesick and bewildered in their own land?

Nearly 3,600 Red Cross workers continue to serve able bodied troops in this country and abroad. Another 2,600 are serving in military and naval hospitals here and overseas, doing recreational, medical, and psychiatric work.

Assistance by the Red Cross already has been given to a long-stretched line of approximately 1,700,000 veterans at the time of their separation from service. Red Cross field directors are serving in 62 Veterans Administration regional offices, with more than 1,500 trained Red Cross workers engaged in Veterans Administration programs. Millions of volunteers are doing recreational and other work in veterans' hospitals.

An incident points up the fact that although the war has left its weary stamp on thousands of victims, through the patient efforts of Red Cross workers many of them are fighting their way back.

A sergeant, afflicted with a speech deficiency as a result of combat, was lying mute on his hospital bed when a Red Cross girl came humming to his side. His blank face lighted up.

"Like music?" she asked. He nodded.

So she began teaching him to form the words of a song. At first she had to sing by herself, but gradually be joined in, word by word, his eyes pleading for help. Then one day she had her reward. He sang the song all alone, tears rolling down his cheeks. It was "America."

The warm heart of America expresses itself through the Red Cross. Let's all dig deep in our pockets and keep those banners flying.

### Medical Care

*Reprinted from The Torrington Register*

With a view to developing a statewide program to improve rural health services, the Connecticut State Medical Society is preparing a questionnaire

to be mailed shortly to the heads of civic organizations in small communities. Recipients of the questionnaire will be asked such things as these: "Do you think your community has enough doctors?" "Do you think you have good, fair or poor hospital facilities?" and "Do you think your ambulance service is adequate?"

So far as Litchfield county is concerned—thanks to the excellent hospital facilities afforded by Torrington, Waterbury and Winsted—conditions on the whole probably are considerably above the average. However, in some sections of the state there undoubtedly are rural areas where lack of adequate medical facilities poses a serious problem.

If the State Medical Society is successful in ameliorating these conditions it will have performed a valuable service.

These days, more than ever before, stress is being placed on the importance of preventive measures and the present move by the Medical Society is in strict accord with this program, because, after all preparedness is one of the keynotes of prevention—in medicine as in other things.

The following editorial appeared in the December 13 issue of the *New Haven Evening Register*.

### Public Health Propaganda

The American Medical Association's House of Delegates by unanimous resolution censures the Surgeon General of the United States Public Health Service for "political activities." The rebuke thus delivered to Dr. Thomas A. Parran for his reputed efforts toward propagandizing President Truman's compulsory health insurance plans appears a deserved one. The surgeon general's department was established and is now financed to promote the public health and to take leadership in the fight against disease. It was not created to engage in partisan politics or to attempt the foisting of new methods of restriction and control upon the American people. Its interest in the unwanted Wagner-Murray-Dingell compulsory health measure, if any, should be academic, not promotional.

It was charged before this medical group that Dr. Parran in a letter to all staff members issued orders that all their public utterances be guided by, and in support of, President Truman's 1945 message to Congress pumping for this health regimentation scheme. Any such order is comparable to that of the



President when he attempted, fortunately with small success, to gag Navy spokesmen in their opposition to a one-sided merger of our armed forces.

Such political activity should have no place in the nation's health service organization. It has been conclusively demonstrated on numerous occasions that adoption of any such system as that advocated in the Wagner-Murray-Dingell bill could have but a single result. This would be the utter regimentation of every employed patient and physician in this country. This would be accomplished through the additional evil of a tremendous increase in taxation. It would throw open the road to medical stagnation and health by directive under bungling and costly bureaucratic methods at a time when an incoming Congress will be confronted with the major task of paring an already over-inflated national budget.

It is indeed unfortunate that a Congress faced with such major objectives should be forced to devote considerable time and attention to any measure so obviously of the planned economy variety. Last November 5 the voters of this nation returned their verdict on regimentation and control from Washington, whether it be in the field of commodities or that of medicine. In addition some 55,000,000 Americans, including more than 650,000 from Connecticut, have cast their vote on the subject of socialized medicine by enrolling for voluntary forms of health insurance or hospital care.

The 80th Congress should find little difficulty in disposing of this compulsory health bill in the proper form. Meanwhile, Surgeon General Parran and his aides would do well to cease and desist from further excursions into the propaganda arena.

### For the Future

The progress made by the Society in the seven years just past as outlined in the Secretary's mid year report must bring satisfaction to all. The report emphasized particularly the addition of more than 500 members to the Society during that period, an increase of nearly thirty per cent, and in simple figures told the improvement of the Society's finances. These things are tangible but many less conspicuous advances have also been made.

Growing as fast as this there has not always been time or people to give thorough consideration to long term planning because everyone has been fully occupied meeting day to day questions.

On the suggestion of the Secretary, the House

voted to establish a Committee to Study the Organization and Objectives of the Society. The committee is to consist of the eight elected county councilors and one other representative from each county association and those who accept appointment on this committee are faced with an almost unequalled opportunity to be of service to the Society and to medicine in Connecticut.

There should be no impatience about making the report for the study must be made in detail and with care. Many things which have grown up in tradition may be outmoded now, our horizon is no longer close or personal and perhaps the only thing that remains unchanged is the ancient integrity of the Society and its willingness to be of increasing service to the people and the profession of medicine.

### The Health Insurance Plan of Greater New York

The Health Insurance Plan of Greater New York popularly referred to as HIP which is about to begin operations represents the most comprehensive city wide plan of sickness insurance that has been attempted in this country. The details of the plan are of particular interest at this time when our own developments in sickness insurance are about to get under way.

The New York Plan is a non profit corporation under management by a governing board representing medicine, labor, management, city government and social welfare. Although membership in the plan is essentially limited to persons receiving a salary or base wage not exceeding \$5,000 there are provisions for individuals earning above this figure. Enrollment is only to be made through employee groups in which at least 75 per cent of eligible workers in a firm or agency must sign up before the group can be accepted and no groups of less than 25 are considered. The plan also accepts spouses of employees and unmarried children under 18.

The services offered by the plan are comprehensive in a wide sense and include, general medical, specialist, surgical and obstetrical care in the home, doctor's office, or hospital; diagnostic and laboratory procedures; periodic health examinations, immunizations and other preventive measures; physical therapy, radiotherapy, professional services for blood or plasma administration, eye examinations, visiting nurse service at home, ambulance service from home to hospital and psychiatric advice. No physical

examinations are required for enrollment and there is no age limitation.

Payment for the plan is shared by both employees and employer. In each instance the latter must contribute at least 50 per cent and he can pay up to 100 per cent of the premium. The total cost is as follows:

\$29.12 a year for an employee with no dependents.

\$58.24 for an employee with one dependent (wife, husband or child).

\$87.36 for an employee with two or more dependents (no limit).

The above rates however do not include hospitalization but through agreement with the associated Hospital Services it is possible to obtain both services in a single contract. The rates for full medical care and hospitalization are:

Single person \$38.64.

Married couple, no children, \$77.28.

Families of three or more \$111.

For those municipal workers who are expected to sign up this year the City of New York has recently appropriated \$500,000. It is anticipated that eventually the number of insured among the city employee group will cost the city around \$4,000,000.

In order to implement the medical service a group practice system is being developed around diagnostic and medical services centers which will be located at geographic advantage. Both full time and part time physicians will be used, the average medical group comprising 20 to 25 men. The HIP subscriber is free to choose any medical group affiliated with the plan within reasonable geographic limitations and may choose any doctor in the group as a family physician. A medical control board sets medical standards and every group seeking affiliation must meet these standards. The five county societies are represented on the board.

The plan as it develops will be watched with great interest for in its magnitude and operation there rests potentialities which could establish fundamentals in medical economics which would influence medical practice in the entire country.

### Doctor Bartlett Honored

December 18, 1946, marked the eighty-second anniversary of the birth of Dr. Charles J. Bartlett, professor-emeritus of pathology, Yale University; president of the Connecticut Medical Examining Board and pathologist of Grace Hospital. The occa-

sion was celebrated by ceremonies replacing the usual five o'clock Wednesday Grace Hospital Clinical Pathological Conference. It was followed by a social hour during which a large number of friends and colleagues offered their congratulations and felicitations.

Dr. Bartlett was taken completely by surprise, since he was prepared to give the pathological findings in what he thought was a regularly scheduled case. Indeed it was not until after reprints of a previously published biographical sketch of him\* had been distributed in lieu of the usual protocol, that he had any thought that his birthday was being honored.

As part of the program, two excellent portraits of Dr. Bartlett were presented to him. One of these was a side view, showing him with his well beloved pipe.

The chief event of the program was the gift of a volume containing over ninety articles which had been written by Dr. Bartlett's staff associates. The book was bound in dark blue. On its cover was inscribed in gold letters:

DR. CHARLES J. BARTLETT'S  
EIGHTY-SECOND  
BIRTHDAY  
ANNIVERSARY  
VOLUME  
DECEMBER 18, 1946

The letter of transmittal at the beginning of the volume reads:

Dear Mr. Bartlett:

We, your professional associates of Grace Hospital, salute you on this happy eighty-second anniversary of your natal day. We are honored in being your colleagues and friends.

To commemorate this auspicious occasion a group of us has gathered together some of our writings into a volume. This we present to you. Some of your friends have added letters of congratulation which are simultaneously presented.

This volume would be many many times as large if we had included all of your former pupils who would have been most eager to join with us. To illustrate this—not very long ago one of your former students, an illustrious man, told me how glad he was to have been your pupil and desired that I con-

\*CONNECTICUT STATE MEDICAL JOURNAL, Vol. VII, No. 3, March 1943.



vey his best wishes to you. His magnificent work and that of many others could swell this humble offering into many tomes. We rather choose to limit it to the men in your everyday life.

It might be said that these articles were not especially written for this occasion. In a larger sense there is something nobler about them since they were prepared by intimate associates many of whom were your pupils when you were Yale's professor of pathology. In this manner something of your teaching spirit has passed into their minds, and lives in their work as part of you, just as your old friend Warthin would say that we live forever in the germ plasm of our progeny.

As your biographer, four years ago, I predicted a long and useful future for you. This prediction has only begun to be fulfilled. I continue to prophesy many happy years of endeavor for the well being of us all. Your firm step and clear eye make me ashamed of my occasional pessimism that this is the twilight of the golden age of medicine. Work! and more useful work is your watchword.

Contend, my soul, for moments and for hours;  
Each is with service pregnant, each reclaimed  
Is as a kingdom conquered, where to reign.

Sincerely your,  
Daniel F. Levy

## The Arnold C. Klebs Library Arrives at Yale

Physicians in Connecticut will learn with interest of the arrival at Yale of the great library of the eminent Swiss medical historian and humanist, Arnold C. Klebs. Receipt of the Klebs collection marks the fulfillment of the plan originally conceived by the late Dr. Harvey Cushing for establishing at Yale a center to promote the study of the history of medicine and science. Although not a Yale man, Dr. Klebs was a life long friend of Dr. Cushing who, shortly before his death, induced Klebs to deed title of his library to Yale University so that their books might one day be united. Cushing at the same time persuaded Dr. John Fulton also to give his collection on the history of physiology to the Medical Library. Others meanwhile have followed suit with the result that we now have in Connecticut one of the most useful and valuable libraries of the history of medicine in the world. To mark the arrival of the Klebs gift, the Historical Library has arranged an exhibit during January and February in which some of the more important holdings have been placed on display.

Arnold Klebs was the son of the well known Swiss bacteriologist, Edwin Klebs, who isolated the diphtheria bacillus prior to Loeffler (hence the "Klebs-Loeffler bacillus") and who was likewise the first to prove experimentally that the tubercle bacillus was the causal agent in tuberculosis (1877). Edwin Klebs wrote some seventy papers on the etiology, pathology, and therapeutic management of tuberculosis, and the originals of all these papers have been carefully preserved, along with a considerable proportion of the books he had gathered together.

Following in his father's footsteps Arnold Klebs devoted his early years of practice to tuberculosis. He came to this country in 1896 and after spending some time with Osler at Johns Hopkins began to practise as a tuberculosis specialist in Chicago. In 1909 he edited a large monograph on tuberculosis which was well received and generally regarded as the most authoritative text in English. Because of his interest in tuberculosis, Klebs soon turned his attention to the early literature of this subject and in the course of the next forty years he brought together a collection of more than two thousand separate items on the history of the disease.

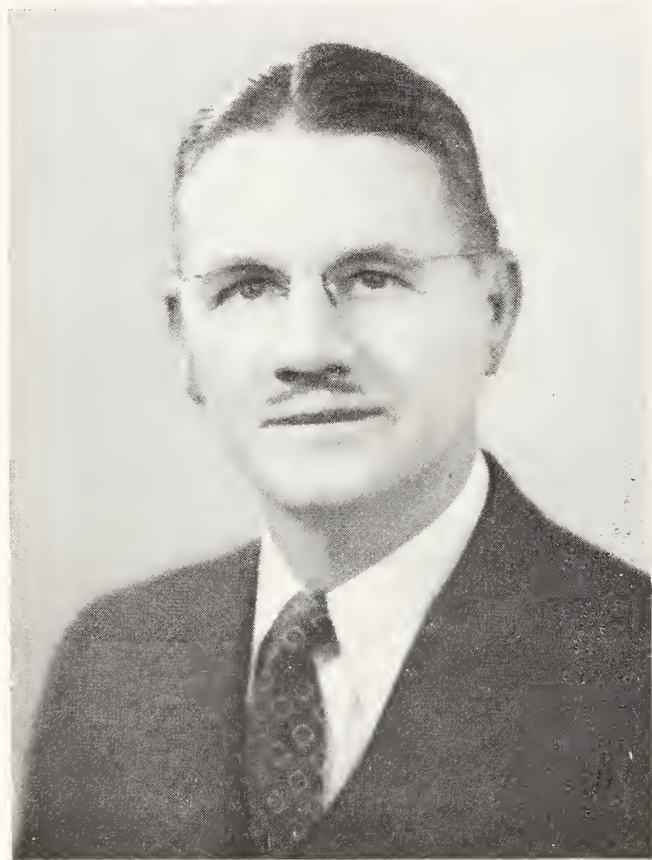
He was also interested in the history of inoculation for smallpox and, as with the tuberculosis literature, he amassed a large proportion of the ephemeral inoculation pamphlets, this section of his library running to more than a thousand items. The early plague tracts claimed his attention, and he likewise had a large collection of early herbals on which subject he had become an eminent authority.

Dr. Klebs' principal contribution to scholarship lay in the field of fifteenth-century medicine and science. He had intended to publish a large-scale bibliography of fifteenth-century medicine and science and in preparation for this vast undertaking, which had been sponsored in part by the New York Academy of Medicine, he issued in 1938 a short-title list, *Incunabula scientifica et medica*. Unfortunately when his death came in March 1943, this larger work had not been entirely completed. The manuscript and extensive general notes relating to individual works have come to Yale with his gift, and the Historical Library hopes at some future time to publish the full length bibliography.

Recognizing their responsibility to the profession in the state and elsewhere in the country, those entrusted with the administration of the Library are making its holdings freely available to all physicians. Any member of the State Society in good standing may use the Library, and books may be borrowed

by arrangement with the hospital with which the physician is associated, or through libraries by means of inter-library loan.

### Dr. Smith Appointed Surgeon General



DR. WILLIAM B. SMITH

Dr. William B. Smith, of Wethersfield, was recently appointed surgeon general, with the rank of Colonel, on the military staff of Governor James L. McConaughy.

State medical officer of the Connecticut Selective Service System during the war, he entered active duty from reserve status in September, 1940, and received his separation in October, 1946, with the rank of Lieutenant Colonel. Following separation he attended a postgraduate course at the University of Pennsylvania School of Medicine, where he received his medical degree in 1922. In the first World War he served overseas with the Pennsylvania Hospital of Philadelphia.

Long active in aviation medicine, Dr. Smith organized at Hartford, in 1929, the first civilian school of aviation medicine in this country. He is a graduate of the U. S. Army School of Aviation Medicine, and has served as an officer of the Aero-Medical

Association, a national organization of medical men interested in aviation.

In December, 1924, he joined the Connecticut National Guard as a 1st Lieutenant, Medical Corps, and was later designated commanding officer, 118th Medical Detachment, and flight surgeon, 43rd Division Aviation, CNG. In 1927 he was appointed chief flight surgeon, Connecticut Department of Aeronautics. He recently resumed his medical practice in Hartford.

### Scott Adams Appointed Acting The Librarian of Army Medical Library

To replace Mr. Wyllis Wright who is leaving to become Librarian of Williams College, Mr. Scott Adams has been appointed Acting The Librarian of the Army Medical Library.

Mr. Adams, who received his A.B. at Yale and his B.S. degree at Columbia came to the library in February 1945, and in July of that year became chief of Acquisition Division. He had served as supervisor, Acquisition Division, Teachers College Library, and later as Order-Catalog Librarian of the Providence Public Library. He is author of the O. P. Market, a Subject Directory to the Out-of-Print Book Trade.

Mr. Adams has been instrumental, through his extensive knowledge of the book field, in contributing substantially to the growth of the Army Medical Library's collections.

### A.M.A. Council on Industrial Health Announces New Appointment

Captain Ernest W. Brown, MC-USN, recently retired, has joined the staff of the Council on Industrial Health of the American Medical Association, Chicago.

C. M. Peterson, M.D., executive secretary of the Council, in announcing the appointment, stated that Captain Brown will act as executive officer for the Council's Committee on Scientific Development and in matters pertaining to industrial medical education and industrial toxicology.

During the recent war Captain Brown was attached to the Office of the Surgeon General of the Navy in charge of industrial hygiene research, submarine medicine and chemical warfare medicine. He also served as liaison officer to the Committees on Industrial Medicine and Armored Vehicles of



the National Research Council.

Captain Brown holds the degrees of PH.B. and PH.D. from Yale University, the latter in biochemistry. He received his Doctor of Medicine degree from the George Washington School of Medicine and attended the Johns Hopkins School of Public Health in 1936-1937.

He retired from the regular Navy in July 1946 after serving for many years on the faculty of the U. S. Naval Medical School in Washington as head of the Department of Environmental Hygiene and as Medical Director of the New York and Washington Naval Shipyards.

gist. Growth has been slow but steady. From a total of seven patient visits in July the clinic increased to sixty-three such visits in October and even more in November.

Practitioners of Healing Arts

During the first six months of the years 1945 and 1946, practitioners of the healing arts registered with the Connecticut State Department of Health as follows:

CLASSIFICATION	NUMBER REGISTERED	
	1945	1946
Medicine and Surgery.....	3,045	3,331
Osteopathy .....	116	120
Chiropractic .....	124	125
Natureopathy .....	96	93
Chiropody .....	173	187
Midwifery .....	40	36
Registered Nurse .....	12,648	13,228
Trained Attendant .....	2,565	2,593

First Hospital Psychiatric Clinic Grows Steadily

Waterbury Hospital opened the first hospital psychiatric clinic in the State on July 3, 1946. In addition to John Staneslow, M.D., part time psychiatrist, the clinic has a social worker and a psycholo-

CONTRIBUTORS TO THE BUILDING FUND — DECEMBER 10 TO JANUARY 10

FAIRFIELD COUNTY			HARTFORD COUNTY			HARTFORD COUNTY—Continued		
Akerson, I. B., Bridgeport			Benjamin, H. W., New Britain			Rosenbaum, G. J., Hartford		
Bria, W. F., Cos Cob			Birge, H. L., Hartford			Roth, F. E., Hartford		
Colburn, R. F., Stamford			Blogoslawski, W. J., New Britain			Sachs, Benjamin, Hartford		
Conklin, C. S., Bridgeport			Clarke, H. A., New Britain			Schaefer, Jacob, East Hartford		
Cunningham, R. D. M., Stamford			Cushman, L. A., West Hartford			Schwartz, H. N., Hartford		
Finn, E. J., Shelton			Dinsmore, W. W., Hartford			Sigal, J. B., Hartford		
Friedberg, Sol., Stamford			Friedberg, I. H., Newington			Slossberg, D. S., Hartford		
Frothingham, J. G., New Canaan			Friery, C. M., Hartford			Smith, W. L., Hartford		
Gates, A. B., Greenwich			Gardy, L. A., Hartford			Sneidman, G. I., Hartford		
Johnstone, K. T., Bridgeport			Geetter, I. S., Hartford			Standish, J. H., Hartford		
Knapp, C. S., Greenwich			Gillespie, Harry, Hartford			Standish, W. A., Hartford		
McLean, T. S., Bridgeport			Goldenberg, J. J., Hartford			Sundquist, A. B., Manchester		
Meeker, D. O., Riverside			Goldschmidt, Myer, New Britain			Tonken, Louis, Hartford		
Nolan, J. F., Bridgeport			Griswold, E. M., Glastonbury			Townsend, W. C., Hartford		
Pease, M. C., Ridgefield			Grossman, Walter, Hartford			Weiner, J. G., Hartford		
Rogers, R. P., Greenwich			Grosvenor, F. L., Hartford			White, B. V., Hartford		
Rosenberg, Hans, Bridgeport			Hellijas, C. S., Hartford			Zaglio, E. R., Manchester		
Rosner, Fred, Bridgeport			Holtz, R. S., Hartford					
Rourke, T. A., Greenwich			Hurwitz, George, Hartford			NEW HAVEN COUNTY		
Sekerak, R. A., Bridgeport			Jenovese, J. F., Hartford			Bruno, Joseph J., New Haven		
Serrell, H. P., Greenwich			Kalett, Joseph, New Britain			Katzenstein, Rolf, Meriden		
Sholler, N. A., Bridgeport			Kaschmann, Joseph, Hartford			Larkin, Charles L., Waterbury		
Swarts, W. B., Greenwich			Katz, Henry, Hartford					
Tarasovic, T. J., Bridgeport			Keeney, R. R., Jr., Manchester			WINDHAM COUNTY		
Thompson, S. A., Greenwich			Levine, S. S., Hartford			Arnold, Morton, Willimantic		
Tinkess, D. E., Greenwich			Lewis, S. D., Hartford			Little, Mervyn and Olga G., Willimantic		
Tunick, G. L., Greenwich			Litter, Leo, Hartford			(Additional pledge)		
Turnley, W. H., Stamford			Locke, H. L. F., Hartford			Prosser, Florence Dean, Putnam		
Unger, Milton, Bridgeport			Maislen, Samuel, Hartford			Todd, Frank P., Danielson		
			Nichols, Edward, Hartford			Welt, Louis G., Willimantic		

## THE PRESIDENT'S PAGE

THE SEMI-ANNUAL meeting of the House of Delegates of the Connecticut State Medical Society on December 30 provided developments of more than passing interest. One of the prime reasons for this meeting was the adoption of a budget for the year 1947. This entailed the establishment of the rate for dues for the same period.

In addition, reports of officers and important committees were submitted. All of this appears elsewhere in the JOURNAL and it should receive your earnest perusal. Particularly, I would urge that you read the reports of the Committee for Study of Workmen's Compensation Laws; the report of the Committee on Prepaid Medical Care, and the recommendations contained in the report of the Executive Secretary. Each of these three subjects was of such vital importance to the Society as to deserve exhaustive discussion and critical consideration.

I am happy to report to you that your elected delegates to the House exercised to the fullest extent their right to debate the issues involved. It spoke well for Connecticut Medicine that those men who had opinions expressed themselves frankly and fully in the discussions. It was heartening to see the interest displayed, and it was stimulating to observe the democratic functioning of this legislative forum of our Society. While there was clear division of opinion on certain subjects, there was complete agreement that no opinion should be stifled and that everyone should have opportunity for expression.

Occasionally it is said by some that the Council "runs" the Society; that it can neutralize the action of the House of Delegates; that the two bodies are balanced each against the other as the Senate and House of Representatives of Congress. None of this is based on fact.

The Council acts as an executive committee of the Society. Its actions are limited by the By-Laws, and in matters of policy it is directed by the mandates of the House of Delegates. The House of Delegates has the power to initiate, criticize, and direct the important and basic affairs of the Society. It is, therefore, of the utmost importance that great care be exercised in the selection of delegates by the County Associations. This is a responsibility that should be felt by every member of the Society.

These men will represent you in the House. They will be responsible to you for the development and continuance of sound policy. They are the men who must maintain the structure and the activities of the Society on the plane that you desire. If you are indifferent, in their selection or if you refuse to serve when chosen, whom can you blame if the conduct of the Society is not to your liking?

Cole B. Gibson, M.D.



## American College of Radiology Recommends Radiologist-Hospital Arrangement

The Commission on Hospital Standards of the American College of Radiology recommends, as the most satisfactory type of fiscal arrangement between a radiologist and the average private hospital, a contract under which the radiologist leases the department at a fixed monthly rental. The agreed monthly rental should cover the use of the space occupied by the department of radiology and the equipment therein, or space alone should the radiologist own the equipment.

An alternative arrangement which permits the radiologist to act as an independent practitioner in the hospital has proved satisfactory in a number of hospitals. Under this method, the radiologist renders bills and collects for all private cases in his own department. The hospital collects for all ward and dispensary cases. The radiologist pays all salaries for technicians and assistants in the department. Films, supplies, other operating expenses, and a monthly item for amortization of equipment on a ten-year basis are charged to "overhead." At the end of the month these "overhead" expenses are apportioned between the radiologist and the hospital according to the ratio of private to ward cases. Thus, the radiologist retains all income for private cases, and the hospital retains all income for ward cases. These gross amounts are reduced by sharing in the expenses of maintaining the department according to the ratio of private to ward cases.

When radiologists are unable to obtain an agreement for a fixed monthly rental or an arrangement under which they operate as an independent practitioner as described above, the Commission on Hospital Standards recommends, as the next most desirable arrangement, a contract under which the radiologist leases the hospital department at a rental based upon a percentage of gross receipts.

The actual figures on prevailing fiscal arrangements between radiologists and hospitals throughout the country today are of interest. Approximately 54 per cent of all radiologists practice their profession on a percentage basis in hospitals. About half these are in the legal position of a tenant, paying the hospital as a rental. The remainder are in the legal status of an employee receiving a percentage of gross or net income as compensation. About 9 per cent of all radiologists lease their hospital depart-

ment at a fixed monthly rental. The balance, or about 37 per cent, are employed on a straight salary.

Among the percentage agreements, by far the greater proportion allow 50 per cent of the gross collections as remuneration to the professional personnel in the department. Only 19 per cent of all radiologists practicing on a percentage basis in hospitals receive less than 40 per cent of the gross collections of the department. In contrast, 71 per cent receive from 40 per cent to 60 per cent of gross receipts. The remainder, or 10 per cent, receive more than 60 per cent. Under most such plans the hospital pays the entire expenses of the department from its portion of the gross receipts. In a percentage-rental lease contract, the College recommends that all operating expenses, including salaries and supplies, be paid by the tenant-radiologist.

There have been frequent statements in the hospital literature of late to the effect that most radiologists prefer to work on a straight salary. It is also alleged that efforts to preserve the practice of radiology in hospitals on a fee for service basis and to retain the position of the radiologist as an independent practitioner of medicine represent the views of only a "small and vocal minority" in radiology.

Anyone familiar with the facts will recognize the falseness of these statements. Principles of the American College of Radiology pertaining to the relationship between radiologists and hospitals have been endorsed by the entire membership and obviously represent the views of the great majority of practicing radiologists. These principles have consistently urged that radiologists be permitted to practice their specialty in the hospital as independent practitioners in the same manner as other members of the staff.

With due regard for certain factors peculiar to the specialty of radiology in hospital practice, the fiscal arrangements outlined above have been recommended. They permit the hospital to be reimbursed from the fees earned by the radiological staff for its entire costs in maintaining the x-ray department with a fair return on its investment in space and equipment. They are consistent with the principles adopted by the Council on Medical Education and Hospitals of the American Medical Association in its hospital approval program. The standards promulgated by the A.M.A. include the provision that "it shall not be the policy of the hospital to make a profit from the department of radiology." The merit

of this principle is recognized by leading hospital administrators and medical men alike.

Each year additional hospitals, after negotiations between the staff radiologist, staff committees, and the hospital administration, change their existing arrangements to one more consistent with the principles advanced by the American College of Radiology.

### Prepayment Plans and Radiology

The American College of Radiology has recently completed a study of the radiologists' position with reference to hospitals and prepayment plans. The study reviews the prevailing arrangements between radiologists and hospitals and recommendations are made.

A rather complete analysis of the present x-ray provisions of prepayment plans is included in the study. The report shows that thirty-three of the eighty-one Blue Cross Plans "have complied with dictums of organized medicine and do not offer x-ray benefits in their contract. The majority of the plans which do include x-ray benefits as a part of hospital care provide for limited benefits. The trend in recent years has been to put a limit expressed in dollars on x-ray benefits, usually \$15. Seventeen plans have such limits, one plan pays up to \$25, and one \$35. Three provide for 50 per cent of charges, one 25 per cent of charges, and seven have various other limitations on x-ray benefits.

"In twenty-four states, thirty-five separate medical care plans sponsored by the state or local medical societies are operating. Twenty-four plans provide an allowance for diagnostic x-ray service. In the majority of plans, the maximum is \$15. Eight plans also include benefits for x-ray therapy according to a schedule of benefits similar to benefits for surgical services. At least two plans that do not include x-ray benefits are preparing to add such benefits to their contract.

"Since prepayment medical care plans are now operating in most of the states, it appears that a simple way to obtain increased cooperation between medical society sponsored medical care plans and Blue Cross Hospital Service Plans would be to transfer all benefits for special medical service to the medical care contract. Such an arrangement would prove to be beneficial to the public, the hospitals, and the physicians as well as to the administrators of both types of plans.

"There are evidences of progress toward this happy solution to the long standing controversy over the furnishing of medical services by hospitals under Blue Cross contracts. In several communities, special medical services formerly included among Blue Cross hospital benefits have been transferred to the medical service plan."

### Trudeau Society Plans Medical Education

The Council of the American Trudeau Society is now developing plans to expand the scope and functions of its Committee on Postgraduate Medical Education. Believing that postgraduate medical education in tuberculosis and chronic chest diseases should become one of the most important activities of the American Trudeau Society, the Council has set up seven Regional Committees throughout the country, and the National Conference of Tuberculosis Secretaries has been invited to help in the development of this expanded program. Courses for specialists, internists, etc., are to be offered in each region during the coming year, under the title of "Thoracic Diseases." Region I, preferably called the "New England Region" covers the six New England States, and members of this committee are: Dr. Theodore L. Badger, chairman; Dr. Kirby S. Howlett, Jr., co-chairman; Dr. Hugh B. Campbell, Dr. John C. Ham, Dr. Donald S. King, Dr. Paul S. Phelps, Dr. Alton S. Pope, Dr. John W. Strieder, and Mabel Baird, executive secretary, Connecticut Tuberculosis Association, as the representative of the National Conference of Tuberculosis Secretaries.

The first project planned is a "pilot course" scheduled by Regional Committee V, to be conducted at the University of Wisconsin Medical School for one week, March 3-8, 1947. A similar course of two weeks' duration was decided upon by the New England Regional Committee at a meeting on November 16, and will be held in Boston in the early fall. Later it is planned to prepare courses for the general practitioner. Dr. Cameron St. C. Guild, who is executive secretary for the Trudeau Society, is representing the National Tuberculosis Association in this program. The costs involved in getting the courses underway have been underwritten by the National Association, and it is hoped that State and Local Associations will wish to stimulate participation by means of grants or scholarships, and also to assist in distribution, publicity, and details of local arrangements.



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## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

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### THE SECRETARY'S REPORT

#### SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES — 1946

Mr. President and Members of the House of Delegates:

So much of the detail of this year's operation has been reported and will be reported later in this meeting, I shall not recapitulate it. But, this year does mark the end of a minor epoch in the Society's history and I shall briefly recount what has taken place during that time.

When I first entered the full time employ of the Society, it was for seven years, that term ends now and presents an interesting period for review. It extends from January 1940 to January 1947.

The tangible things that can be reported are an increase in the membership of the Society of slightly over 500. On January 1, 1940, the membership was 1,723, today it is 2,230. On January 1, 1940, after nearly 150 years of existence, the working capital of the Society was slightly more than \$10,000. Today, it is over \$53,000 not including \$39,000 in cash in the Building Fund and real property valued at \$12,000.

Starting shortly before the period covered, but largely included in these years, the CONNECTICUT STATE MEDICAL JOURNAL has moved into a place of national prominence. In addition to these easily measured things, the Society has become of imperative usefulness to its members and has developed a position in the political and social life of our state that makes it one of the most potent independent agencies.

The war record, although vicarious, is one of which we will always be proud.

You know that the reporting of this substantial progress in so short a time brings me great personal satisfaction, but you also know it is not the work of one person but the result of wise and ambitious leadership from many others during these years. To them all I wish to express my gratitude and appreciation. It has been a pleasant experience and I look forward to its continuance.

Our Society today can be likened to a house. It was originally built 150 years ago, well situated with a firm foundation and a sound frame. It was modest in size but frank in its simple facade. As years passed it could have been remodeled because, substantial as it was, it ceased to be adequate for its purpose, then a few years ago it was suddenly realized that it wasn't big enough, didn't have light enough in it, and the furniture was outmoded and so it was added to from time to time, a wing here and a bay window there and some new windows cut. We were our own architects and we added and changed to meet the exigencies of the moment.

We now have a bigger house, the main part of it is sturdy and fine just the way it was a 100 years

ago, but it is misshapen, perhaps a lot of things have been added that are no longer necessary, perhaps new things should be added. Some of the furniture has become outmoded again and we may be sweeping with old brooms. The layout of the house as it now stands is before you on this chart.

I would like to suggest that we survey our house, have it looked over carefully to see how it can be improved and to seek a plan for future remodeling and addition.

To move abruptly from my allegory, I would like to suggest that this House of Delegates consider the appointment of a committee from the membership to consist perhaps of one member of each county association and one elected councilor to be known as the Committee to Study the Organization and Objectives of the Society and that this committee be given plenty of time and full cooperation in reviewing every phase of the Society's activities; the relation of the Society and its management to its members and the county associations; the Society's finances; committee operations; the placement of responsibility; the relation of the Society to the

public; and the Society's educational purposes. If this is done with skill and with candor and with vision, I believe we can look forward to another period of substantial growth in which we may all participate with pride.

### January Council Meeting

The regular monthly meeting of the Council was called to order by the chairman, Dr. Murdock, on Friday, January 10, at 4:45 P. M. There were present: Drs. Murdock, Miller, Campbell, Speight, Moore, LaMoure, Mullins, Thoms, Weed, Gilder-sleeve, Phillips, Gibson, Howard, the Secretary, Dr. Barker and executive assistant, Miss Mooney; Excused: Dr. Weld.

The Council considered the appointment of the new Committee to Study the Workmen's Compensation Laws which was authorized by the House of Delegates at the Semi-Annual Meeting on December 30, 1946. The personnel of the committee will be announced when acceptances have been received from the persons who were nominated.

The Committee to Study the Organization and Objectives of the Society, authorized by vote of the House of Delegates at the Semi-Annual Meeting, was discussed at length. The president, Dr. Gibson, is proceeding with the selection of the members of this committee.

The Council voted to continue the traditional practice of exempting secretaries of the component county associations from the payment of dues.

Dr. Joseph I. Linde, New Haven, was named as the representative of the Society at the Regional Conference on Social Hygiene, New York City, Wednesday, February 5, 1947.

Preliminary consideration was given to nomination of officers and committees of the Society for 1947-1948. The Council was aided by suggestions received from New Haven County Medical Association in response to its requests for such suggestions sent to the secretaries of the county association on October 28, 1946. No other counties responded to this request.

Tuesday, February 4, was set as the date for the next regular meeting of the Council and the meeting adjourned at 6:30 P. M.

### Medical Institutions Approved Under the G.I. Bill of Rights

The following Connecticut institutions and programs have been recommended for approval by the Society and approved by the State Department of Education:

Stamford Hospital, Stamford, x-ray technician.

Waterbury Hospital, Waterbury, mixed residencies, residencies in anesthesia and residencies in surgery.

### Separated From Military Service

The following member of the Society has been returned to civilian status from military service:

Lavietes, Paul H., New Haven (A)

### Meetings Held During January

Thursday, January 9, 3:00 P. M.

Committee on Public Health

5:00 P. M.

Program Committee

Friday, January 10, 4:45 P. M.

Council of the Society

Wednesday, January 15, 6:00 P. M.

Council of New England State Medical Societies, Boston

Friday, January 17, 6:00 P. M.

Committee on Prepaid Medical Service, Graduates Club, New Haven

Wednesday, January 22, 4:00 P. M.

Committee on Maternal Morbidity and Mortality

5:30 P. M.

Committee on Industrial Health, Dr. C. F. Yeager's residence, 178 Jackman Avenue, Fairfield

### Meetings Scheduled For February

Tuesday, February 4

Council of the Society

Wednesday, February 26

Committee on Industrial Health



## New Haven Tuberculosis and Health Association

A new association incorporated as the New Haven Tuberculosis and Health Association was organized on October 21, 1946, for the purpose of conducting a broad and expanded program of tuberculosis education, case finding and rehabilitation in New Haven. Following a survey made by the National Tuberculosis Association, the recommendations were discussed at a conference some months ago with representatives of the Employees Tuberculosis Relief Association, and the State and National Associations. As a result of this conference the Employees Tuberculosis Relief Association decided to restrict its activities to its primary purpose of relief for industrial workers and their families, and therefore a new group should be organized to develop the broader program as outlined in the authorized forms of tuberculosis work to be financed by the sale of Christmas Seals.

Professor Ira V. Hiscock, acted as temporary chairman of the organizing group, with Miss Helen M. Currier as temporary secretary, and a constitution was adopted naming the following objectives for the Association: To conduct an educational campaign against tuberculosis and for the promotion of health; to develop effective health education

methods; to ascertain unfulfilled health needs; and to cooperate with official and other health agencies.

Officers and directors elected to serve until the first annual meeting include: Dr. David R. Lyman, president; H. Gordon Sweet, vice-president; Mrs. Stuart H. Clement, secretary; and W. Herbert Frost, treasurer. In addition to these officers the following comprise the Executive Committee: Professor Ira V. Hiscock, Dr. Joseph N. D'Esopo, and Miss Gertrude Touchton. Other directors include: Dr. Creighton Barker, D. Spencer Berger, Rev. William J. Daly, Mrs. Theodore S. Evans, Mrs. James Ross Gillie, Patrick J. Goode, Mrs. Edward H. Goin, Mrs. Clarence A. Hadden, Mrs. Frederick W. Hilles, Mrs. Samuel C. Harvey, Richard C. Lee, Dr. Joseph I. Linde, Raymond A. Loring, Miss Elsa Montgomery, Justin L. O'Brien, Dr. Arnold B. Rilance, Gino Santella, Rev. Philip G. Scott, Maurice B. Ullman, and Dr. C.-E. A. Winslow.

## Connecticut Surgeons Recently Elected to Fellowship in American College

Eric H. Blank, New London; Frederick S. Kinder, Bridgeport; Anthony J. Loiacono, New London; John F. McGrath, Hartford; Harry R. Newman, New Haven; John F. Nolan, Bridgeport; W. Leslie Smith, Hartford; Benjamin R. Reiter, Bridgeport; Vincent J. Vinci, Middletown; John T. Winters, Hartford; Michael S. Zeman, Hartford.

## Psychiatric Clinic Opens in Hartford

The establishment here of a psychiatric clinic, the fifth in Connecticut, has been announced. It was opened January 2 under the direction of Dr. Edward L. Brennan, senior psychiatrist at the Institute of Living for many years. The clinic, a long time project of the State Health Department, will be subsidized by funds authorized by the 1945 General Assembly. Other clinics are located in Waterbury, Stamford, New Haven and Greenwich.

## Ciba Medical Slide Rule Slips Up

Due to manufacturers' error in placement of decimal point, conversion from 0.4 grain to gram is incorrect. It should read 0.025 gram, not 0.25. Correction should be made by replacing present celluloid table with corrected temporary paper table now being mailed to you.

The American Medical Association is going to celebrate its centennial in Atlantic City, June 9-13, 1947. Elaborate plans are being made for this celebration.

Only Fellows and Invited Guests are eligible to attend. Membership in your state society is the primary qualification for Fellowship in the A.M.A. Fellowship dues and subscription to *The Journal A.M.A.* are both included in one annual payment of \$8, which is the cost of *The Journal* to subscribers who are not Fellows.

If you are not a Fellow and plan to attend the Atlantic City session, which will be a milestone in medical history, you can save yourself considerable time and confusion when registering, if you will write now to the American Medical Association, 535 North Dearborn Street, Chicago 10, and ask if you are eligible to become a Fellow.

## HOUSE OF DELEGATES, CONNECTICUT STATE MEDICAL SOCIETY

New Haven, December 30, 1946

The 1946 semi-annual meeting of the House of Delegates was called to order at 3:00 P. M. on Monday, December 30, 1946, by C. Frederick Yeager, first vice president. Dr. Yeager's introductory remarks were as follows:

For the past decade, and most particularly, the past year, physicians have been made to realize that the practice of medicine is not entirely a profession. Our role has broadened and will perhaps continue to expand. One need only glance at the agenda of the medical meetings or compare the number of medical committees necessary today with those of yesterday to see the changes taking place.

Being somewhat associated with industry, I have come to realize that the success of a business largely depends upon giving the public their money's worth and successful businesses are constantly working in their research laboratories to anticipate and develop better things for better living.

Very recently there appeared in the *Journal of the A.M.A.* an article which severely indicted a certain group of physicians and industries for not providing and anticipating adequate medical care for their patients and employees. It is estimated that the mechanical, metal and mining trades alone represent 15 million people. Our medical profession is constantly being challenged.

We can be proud of our State Society and its officers who have piloted so well our destiny and have met successfully most of the challenges and public demands. They are constantly looking forward. You will now hear from our genial and hard working President who has distinguished himself, particularly during the past half year, by successfully managing the problems which confronted our profession—This Business of Medicine . . . Dr. Cole B. Gibson . . . (Dr. Gibson's address appears elsewhere in this issue of the JOURNAL.)

## REPORT OF THE CHAIRMAN OF THE COUNCIL AND THE DELEGATES TO THE AMERICAN MEDICAL ASSOCIATION

Mr. President and Members of the House of Delegates:

Since the annual meeting held in Hartford in May the Council has carried a very heavy schedule. The members have attended the meetings well and have been industrious in your behalf.

The work during the summer months went on as usual with an executive committee, selected by the Council, carrying on the work.

At the November meeting, and for the purpose of brevity, the Council limited the number of committees to report here today. If there are any other points of information desired by the delegates and not covered in these reports such a request will be granted.

The annual meeting of the American Medical Association was held in San Francisco in July. Dr. Olin West was elected President-elect of the Association. A very great tribute and honor to a very great man. The only important contest was for the speakership and Dr. Roy Fouts of Omaha was re-elected. Dr. George Lull, the new secretary, did a very fine job in carrying out the manifold and detailed duties necessary in running a large convention. I think American medicine is fortunate in obtaining such a capable man to replace Dr. West. The Raymond Rich Associates, engaged to make a study of public relations of the American Medical Association, have made their report part of which was reported to the House. In the time allotted an enormous amount of ground was covered and much progress made. The transactions have been published in the *American Medical Association Journal* and it would be poor duplication to attempt to cover it here. I can say, and I think with pardonable pride, that your delegates were diligent and attended all of the sessions.

The semi-annual meeting was held in Chicago early this month. This was the first semi-annual meeting of the association ever held. Opinions varied as to the necessity for it. At any rate much ground was covered and important legislation enacted. The final report of the Raymond Rich Associates was submitted. Final action was taken on all points covered excepting that part dealing with the National Physicians Committee. This was postponed for further study. The studies by the Rich Associates and the committee to study their report were exhaustive. It is obvious that the expense incurred in carrying out the recommendations will be great.

I cannot pass this opportunity without mentioning a word of sincere praise and admiration for your President-elect, Dr. James R. Miller. It is one year since his election to the Board of Trustees of the American Medical Association. Already he is adding his strength to the Board and contributing much original thought to its efforts. We are all justly proud of him.

The Council has given sincere and whole hearted cooperation to the many committees working for the state society. Many of these are to report here today. These will include important and serious reports from the Committee on the Study of Workmen's Compensation Laws; the Committee on Medical Care of Veterans; Committee on Prepaid Medical Service; Board of Trustees of the Building Fund. I ask your whole hearted cooperation in the solution of these problems.



The prepaid medical committee report will be presented to you today. It is an important document. The finances of the society, which could well have been placed in jeopardy are now secure. I believe the report will please you.

Commendation is due the veterans committee for the great amount of work it has done and the results accomplished. Connecticut now takes its rightful place in the care of veterans.

The various other committees have done outstanding work for the society and I bring the praise of the Council to you for them. The Society owes a debt of gratitude to all committees for their work and accomplishments.

On our visits to the County Medical Associations we asked the aid of the officers, particularly the secretaries, in the selection of members of the Society for committee appointments. We have written to the secretaries asking for their help. To date we have not received any recommendations. We again ask your help in this matter.

As you will hear from the Treasurer's report the financial condition of the society is sound. The Council, as your finance committee, aims to keep it so.

It will be a great day for Connecticut Medicine when we have our own business home with suitable working facilities. Our present quarters are small, poorly arranged and totally inadequate.

The Council again brings its sincere praise for the work of your secretary, Dr. Creighton Barker. Untiring in his efforts, stimulating and original in his thoughts, he has been a tower of strength to the Council.

The Council hopes that the House of Delegates will continue to establish the sound policies which it has always done in the past. Speaking for the Council I assure you of our unalloyed support.

Respectfully submitted,  
Thomas P. Murdock

## REPORT OF THE EXECUTIVE SECRETARY

Dr. Barker's report is published in the section, From The Secretary's Office, in this issue of the JOURNAL.

## ACTION ON THE BUDGET OF THE SOCIETY AND ON THE DUES FOR 1947

The proposed budget for 1947 as presented by the Treasurer was approved by the House. The dues for 1947 were set for twenty dollars (\$20.00).

## PROPOSED AMENDMENT TO THE SOCIETY'S CHARTER

The following proposed amendment to the Society's charter was approved:

"The Council recommends to the House of Delegates that the Secretary of the Society be directed to introduce a private act before the 1947 Session of the Connecticut General Assembly to amend Section (1) of the charter of the Society which now reads, ' . . . and may also purchase, receive,

hold and convey any estate, real and personal, to an amount not exceeding one hundred thousand dollars,' by placing a period after the word 'personal' and the deletion of 'to an amount not exceeding one hundred thousand dollars'."

## REPORT OF THE COMMITTEE ON PUBLIC HEALTH

For at least eight years there has been from time to time consideration of the responsibilities of the health officers of our State and possibilities of increasing their usefulness in the light of the present day concept of Public Health opportunities and obligations.

At the October 31 meeting of the Public Health Committee it was voted to recommend to the Council and House of Delegates of the Connecticut State Medical Society the approval of the establishment of full time health districts throughout the State of Connecticut under the supervision of full time health officers. It was also voted to recommend to the Council of the Connecticut State Medical Society the appointment of a Committee to cooperate with the Commissioner of Health concerning ways and means to implement the foregoing action.

The Council referred the first recommendation to the House of Delegates for action and voted to request a subcommittee from the Public Health Committee to analyze the legislation to be proposed relative to the creation of full time districts, and to present its analysis at the December 30 meeting of the House of Delegates.

In the June 1939 JOURNAL of the Connecticut Medical Society, Dr. C. Bradford Walker, then Health Officer of Cornwall, had a significant paper calling attention to our situation. He pointed out that in 1938 there were only ten states in the Union without some full time local health service in rural areas. Connecticut was one of those states, although there were full time public health nurses in numerous districts. In the June 1942 issue of our JOURNAL there was another challenging article on Local Health Units by Dr. George Palmer, Associate Field Director of the Public Health Association.

Under our present system there are numerous loopholes in desirable activities of Health Officers. I think there can be no question that not only in the over crowded war years, but for some years earlier, many part time health officers have had to leave undone several important health activities—e.g.:

1. Adequate supervision of immunization—diphtheria and small pox especially.
2. Health education.
3. Encouragement of various programs of control—tuberculosis, venereal disease.
4. Satisfactory reporting of communicable diseases with follow-up where indicated.
5. Incomplete sanitary inspection.
6. Occasionally part time health officers are reluctant to press charges against offenders who happen to be their patients.
7. The remuneration received by part time health officers does not permit a large expenditure of time.

Full time units could be expected:

1. To get more complete morbidity statistics—so necessary for better control of communicable disease.

2. To bring to bear the newer aspects and methods of health education, correlating the interests of the varied voluntary health agencies interested in Cancer, Tuberculosis, Polio, Visiting Nurses, Venereal Disease, Child Health, Deafness, Blindness, etc.

3. Gain the cooperation of more of the practicing physicians in the community in Public Health activities.

In June 1942 the House of Delegates of the American Medical Association passed a resolution urging the establishment of full time, modern, health services to provide complete coverage of the nation's area and population. The American Public Health Association passed a comparable resolution in October of the same year. On November 20 of this year, at the official meeting of the Health Officers of Connecticut, a resolution was passed urging the establishment of full time districts of health in Connecticut.

Objections to full time Health Districts have been suggested:

1. On the part of the people, that their expenses would be increased; small towns would lose their identity and control over their own health problems.

2. On the part of present part time health officers,—some want to hold their position because of their sincere interest in the work; some want to continue the remuneration it brings in, and retain the authority of appointment of sanitary inspectors, etc.

3. Properly trained personnel are not available.

There are two proposed means of bringing about full time health districts and full time health officers:

1. A voluntary association of two or more towns into a sanitary district—under the supervision of a health committee, representing proportionately the population covered, who would employ a full time, qualified, health officer, approved by the Public Health Council. To stimulate this association of towns into larger sanitary districts the Department of Health proposes to match town funds, dollar for dollar, thus assuring adequate coverage without appreciable increase over present town expenditure for health. This is a voluntary association of towns into a working arrangement—the stimulus arising within the communities themselves, with no outside pressure other than any legitimate efforts to urge action.

2. Another proposal would be a division of the State into Health Districts—not on a County basis, but on the basis of areas naturally centering their business life in a larger community. Perhaps ten of these areas would make up the State. Each would have a complete health service with laboratory facilities, and clinics such as now under the supervision of the municipal Departments of Health. This is the plan proposed in the so-called Emerson Report of the American Public Health Association of January 1945. It would necessitate mandatory legislation for its establishment. This may not be readily forthcoming in Connecticut.

The sub-committee of the Public Health Committee reports favorably on the Bill sponsored by the Department of Health because:

1. It is a voluntary program. Health districts thus formed will be the result of the cooperative interest of the towns

themselves, and will retain, in substantial measure, the identity of the towns.

2. It appears workable and should show normal growth.

3. The early adoption of this Bill seems probable, whereas the passage of a mandatory measure might delay for a considerable time the formation of much needed full time health units.

I therefore move that the House of Delegates of the Connecticut State Medical Society approve the establishment of full time health districts throughout the State of Connecticut, under the supervision of full time health officers.

I further move that the House of Delegates endorse the Health District Bill proposed by the State Department of Health, which would encourage the establishment of full time districts of health by the provision of financial assistance from the State of Connecticut.

Respectfully submitted,  
Howard S. Colwell

#### RESOLUTION CONCERNING AN INCREASE IN NUMBER OF COUNCILORS FROM COMPONENT COUNTY ASSOCIATIONS

The New Haven County Medical Association submitted a resolution to provide for an increase in the number of councilors. This resolution was tabled and the President was directed to appoint a special committee of sixteen to include the eight County Association Councilors and one additional member from each County Association to study the organization and objectives of the State Medical Society.

#### RESOLUTION CONCERNING THE NATIONAL PHYSICIANS COMMITTEE

The following was passed concerning approval of the policies and activities of the National Physicians Committee for the Extension of Medical Care:

"The Council of this Society, recognizing the consistently effective work of the National Physicians Committee for the Extension of Medical Service in informing the public of the values, methods and achievements of American medicine, wishes to recommend to the House of Delegates: that this Society approve the activities of the National Physicians Committee and urge its members to increase their interest in and support of the Committee's objectives."

#### REPORT OF THE TRUSTEES OF THE BUILDING FUND

This report will be published in a later issue of the JOURNAL.



## REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

This report will be published in a later issue of the JOURNAL.

## REPORT OF THE COMMITTEE TO STUDY WORKMEN'S COMPENSATION LAWS

The report submitted by the special committee to study the Workmen's Compensation Laws was tabled. The committee was discharged with thanks and the Council directed to appoint a new committee to reengage in this study.

## REPORT OF THE COMMITTEE ON PREPAID MEDICAL CARE

Gentlemen:

When the Connecticut Plan for Hospital Care, the Blue Cross, declined to act as the agent to market contracts for prepaid medical insurance on behalf of the proposed Connecticut Plan for Medical Care, the Council of the Connecticut State Medical Society appointed a new committee on Prepaid Medical Care. This committee was charged with the duty of advising the House of Delegates concerning the extension of Prepaid Medical Insurance in Connecticut. The Committee consists of Drs. Thomas Murdock, Joseph H. Howard, Cole B. Gibson, Herbert Thoms, and James R. Miller, chairman, and now presents the following report and makes certain recommendations:

Your committee feels that the time and money spent by the Society in exploring the field of prepaid medical care has been worthwhile. The Society now stands free from entangling commitments at a time when some plans are having difficulties. Your committee believes it has a clear concept of what is needed in Connecticut.

We are convinced that a successfully operated plan for medical insurance is not within the capabilities of amateurs, but rather calls for the knowledge and experience of professionals. In other words, we believe that insurance should be written by insurance companies.

We have observed the effects of the depreciation in purchasing power of the dollar which goes under the name of inflation, and the disturbing effects these changes have on plans of the service type. We are convinced that premiums collected as dollars should be paid out in benefits as dollars, not as guaranteed service.

The consequences of this conclusion are far reaching. They vastly simplify the problem of administration. It follows that there will be no need for setting a level of income to determine the method of payment of benefits. All of the difficulties of furnishing guaranteed service instead of a cash payment are eliminated. Patient and physicians will continue to arrange the fee by mutual agreement.

Connecticut people at the present time are widely enjoying the benefits of this type of protection against medical and hospital expenses. Over ten per cent of our population is so covered. These contracts have given general satisfaction alike to the patient, the physician, the employer, and the hospital.

We believe, however, that this type of insurance should be extended to cover catastrophic illness for more and more of the population, and furthermore that the extent of the benefits should be broadened step by step to cover medical as well as obstetrical and surgical illness. Various insurance companies licensed to operate in Connecticut already write insurance which we believe to be of great social usefulness, but many more persons can be covered and it is certain that the medical profession can assist greatly in increasing the sale of these contracts. We believe that the contracts offer dependable coverage and return a substantial amount of the premium dollar as benefits and that they can be made even better.

We note that there is an increasing demand on the part of the public, especially of labor and management, for insurance contracts in addition to those for medical and hospital expenses, namely benefits paid in the event of death and accident, and benefits paid for absence from work caused by illness. We note that employers who turn to insurance companies to carry their liabilities under the Workmen's Compensation Law are inclined to turn to these same companies for other lines of insurance. We note also that employers are increasingly giving to their employees insurance for one or more of these needs. In some instances they are paying the whole cost and in others are giving substantial help to their workers in purchasing the insurance. In some instances some of these arrangements are being made as part of the contract between management and labor.

Your committee has studied insurance contracts presented by five companies. It would not be proper for us to comment on features of these contracts other than those having to do with medical and hospital expense. In so far as these items are concerned, we are prepared at the present time to advise members of the Connecticut State Medical Society to commend them to their patients.

The committee, therefore, requests that it be authorized by the House of Delegates to examine and to approve on behalf of the Connecticut State Medical Society contracts covering medical and hospital benefits submitted to it by insurance companies licensed to operate in Connecticut.

It is further recommended that the House of Delegates instruct this committee to be alert to observe (1) that the contracts which it has approved are promoted without extravagant or misleading statement. (2) that enrollment practices are sound. (3) that free choice of physician is maintained, and (4) that complaints and difficulties are promptly and satisfactorily adjusted.

It is recommended that the committee be authorized, subject to approval by the Council, to appoint boards of review to provide for satisfactory adjustment of complaints. These boards are to consider complaints brought by representatives of the insurance company, by subscribers or by physicians.

It is recommended that the committee be instructed to report annually to the House of Delegates on the extent to which the people of Connecticut are covered by medical and hospital insurance, and on the agencies which write such contracts, and in particular, to report on progress in developing benefits for medical as well as surgical and obstetrical illness.

It will be seen from this report that your committee recommends no plan with elaborate mechanisms for the provision

of medical care but rather the employment of mechanisms that society has already found useful. We feel that the medical profession and the insurance industry can work together in harmony and in closer cooperation than has been the case in the past to make these mechanisms more beneficial. This is a great opportunity for the insurance industry to demonstrate its social usefulness and with the help of the medical profession to provide the public with a ready means to cover the unexpected costs of illness.

Respectfully submitted,  
James R. Miller, Chairman

### REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

The Committee on Rural Medical Service is young both in the ages of its members, and in the time the committee has served, but what it lacks in years it makes up in enthusiasm.

We have had only two formal meetings. At the first plans for a questionnaire to be sent to those doctors having a rural practise were made. This was sent out in the late spring, and the number of returns was gratifying. The second meeting held early this fall was attended by Mrs. Ruth Clark, State Home Agricultural Extension Agent, at which time it was decided that in order to really find out what the rural people expect and need, it would be essential to direct questions to them instead of only to the doctors serving them. This questionnaire has been prepared and is even now being distributed. At this meeting, also, tentative plans were made for a conference of those living in rural areas and other interested groups as a means of furthering our service and attempting to guide them in better health principles. It is expected this conference will be held at our own State University in the early summer. It was my privilege to attend a similar conference at Purdue last August. The attendance was good, and enthusiasm high.

We on the committee stand ready to address any farm groups who may request it as far as we are able.

We earnestly hope that by our efforts we may foster the evident desire of those living in rural areas to cooperate with organized medicine in an attempt to make better health available to them. We further feel that this is our chance to show what can be done without direction from federal agencies, and *we dare not let it pass!*

Norman H. Gardner, Chairman.

### REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

Your Committee on National Legislation has kept a close watch on the bills relating to medicine during the last Congress. The following bills were approved by your Committee and passed by Congress; The Hill Burton Hospital Construction Act and the National Mental Health Act.

House Bill 1362, amending the Railway Retirement Act to provide disability payments and other benefits, was opposed by us but was passed by Congress through skillful political maneuvering.

The following bills died in Congress: S1606—The Wagner-Murray-Dingell bill, S1318—The Pepper bill, S1271—provid-

ing funds for industrial health activities to be made to Labor Departments, and the Neely-Pepper bill providing for the appropriation of \$100,000,000 for research of Cancer.

Already there are whispers of a renewed effort to get medical legislation before the next Congress. Senator Taft has requested that the A.M.A. and the State Medical Societies review his bill, S2143 and offer constructive criticism.

In October your Committee reviewed S2143, known as The National Health Act of 1946, the Taft bill, and made the following recommendations:

1. That a National Health Agency be formed—this is in accordance with the resolution passed by the House of Delegates of the American Medical Association.
2. That the National Health Agency be headed by an Administrator and a Deputy Administrator.
3. The Deputy Administrator, instead of the Surgeon General of the United States Public Health Service should be designated to act in place of the Administrator, when necessary.
4. All state plans to be approved by the Administrator and not the Surgeon General of the United States Public Health Service.
5. A State Health Agency be set up to administer the state program. The Administrator to be appointed by the Governor.
6. A Medical Advisory Committee be appointed to aid the Administrator of the State Health Agency.

Respectfully submitted,  
Oliver L. Stringfield, Chairman

### REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH

The committee has met twice since the summer vacation; the first on October 23, 1946 at the executive secretary's office, in New Haven, and the second, at the Waterbury Country Club on November 20, 1946. However, several of the sub-committees have met continuously during the summer months. In view of the fact that there have been only two regular meetings since the annual meeting of the House of Delegates, the chairman was instructed to present only a brief report at this time.

Members of this committee took a very active part in the Seventh Annual Congress on Industrial Health, September 30 through October 2 at the Copley Plaza Hotel in Boston. This meeting was jointly sponsored by The Council on Industrial Health of the American Medical Association, Council of New England State Medical Societies, and the Massachusetts Medical Society. A total of 435 physicians were registered for the Congress, covering 28 states, in addition to representatives from countries in South America, England and Canada. Twenty-five physicians registered from Connecticut. The registration, although largely northeastern, was none the less country-wide representative and far exceeded the expectations. The gracious welcome extended by the officials included the Honorable Maurice J. Tobin, Governor of Massachusetts. Unquestionably, the program of the Congress was the best that has ever been presented on Industrial Medicine and allied medical specialties.



This committee was very fortunate to be the guests of the American Brass Company in Waterbury for its second meeting. The meeting began at 3:45 p. m. Immediately following a short business session, the meeting was turned over to Dr. Andrew J. Jackson, medical director of the American Brass Company, who had carefully planned a very excellent scientific session. Dr. Harold L. Higgins, medical director of the Sylvania Electric Products, Incorporated, Salem, Massachusetts, gave a paper on "Unusual Industrial Pulmonary Diseases." Dr. Higgins' presentation on "Sarcoid Granulomatosis of the Lung," proved that he is an outstanding authority on this subject. The paper was discussed by Dr. Albert S. Gray, director of the Bureau of Industrial Hygiene of the State Department of Health; Dr. Cole B. Gibson, president of the Connecticut State Medical Society and superintendent of Undercliff Sanatorium, Meriden, Connecticut; Dr. S. M. Atkins, consultant radiologist for the American Brass Company and Mr. John Freeman, metallurgist and technical manager of the American Brass Company.

After the scientific meeting, the members of the committee were again the guests of the American Brass Company at a reception and dinner in the Waterbury Country Club. Following the dinner Mr. Ralph Benedict, vice-president of the American Brass Company and Mr. John A. Coe, Jr., executive vice president of the American Brass Company spoke about "Industrial Medicine and its Role in Present Day Industrial Relations." Mr. Allen Rockwell, works manager of the Waterbury Branch of the American Brass Company, gave a very excellent paper on "The Coordination of the Functions of the Medical Department With Management's Job of Production. The meeting adjourned at 9:30 p. m.

The success of the meeting was largely dependant upon the representation and, the interest shown, by the officials of the American Brass Company. This type of meeting proved conclusively that industrialists are extremely interested and sensitive to industrial medical research and that serious consideration should be given to promoting more meetings of this type.

C. F. Yeager, Chairman

## REPORT OF COMMITTEE ON PUBLIC RELATIONS

This report was prepared for the committee by Mr. James Burch, Public Relations director for the Connecticut State Medical Society. The contents of the report was discussed by C. C. Burlingame, M. D., chairman, and by Mr. Burch. It is herewith published in full:

Organization of the public relations section of the Society was begun on August 15, 1946. Since communication is a basic requirement for the movement of information and ideas, the first consideration has been to develop all channels of communication which can be used to tell about the activities and accomplishments of the Society.

### NEWSPAPERS

Editors and managing editors of all Connecticut daily newspapers have been visited. The state has 20 evening

papers, 6 morning papers, and 5 Sunday papers. The purpose of these interviews has been to develop an attitude of friendly interest in the problems of medicine and to acquaint editors with the functions of the Society. In addition to the daily papers, 31 of the state's 42 weekly newspapers have been visited to date.

The results of these visits have been gratifying in most cases. Editors throughout the state generally have a live interest in medical problems, and appear to be strongly opposed to federalized medicine. However, it was noted that in a number of cases, while the editor felt quite strongly opposed to such measures as the Wagner-Murray-Dingell bill, his paper had taken no editorial stand in the matter.

### NEWS RELEASES

Twenty-seven releases have been written for the daily and weekly newspapers. These have been well accepted in all instances and have received good coverage. Front page placement has been accorded on several occasions.

The present shortage of newsprint and increased costs of publication have forced many publishers to curtail the number of pages in their papers. Consequently, it is sometimes difficult for them to devote as much space to a story as desired. Some editors feel that this situation will ease somewhat in early 1947.

### WIRE SERVICES

Particular effort has been made to develop the use of the newspaper wire services, such as the Associated Press and the United Press. This has met with a good measure of success. In several instances releases have been transmitted through the wire services and also mailed directly to editors, with the release date set about five days in advance. This, of course, cannot be done when spot news is concerned.

### RELEASE OF JOURNAL NEWS

During the past two months a new type of release has been written concerning clinical papers appearing in the CONNECTICUT STATE MEDICAL JOURNAL. These are written from the galley proofs of the JOURNAL and released prior to that publication's date of issue. Release is through the wire services.

This type of release has received good coverage, and an effort is made to supply two such releases each month, one for evening and one for morning papers. However, this is sometimes restricted due to lack of material which can be treated in this manner.

### PICTURE STORIES

Another type of news development which is currently being experimented with is the "picture-story." Recently such a story, entitled "Connecticut's Family Doctors and the V.A. Join Forces to Bring Home-town Medical Care to the State's War Veterans," was written. This story comprises approximately 250 words of copy and cut-lines for seven pictures. Arrangements for the pictures have been made, and they will be taken by newspaper photographers. It is probable that this story will not be published until after the first of the year, because of the present high demand for holiday advertising space. It was written to promote the Veteran's Medical-Care Plan and, following its initial

publication, all evening papers in the state will be requested to cooperate in publishing similar stories as a service to veterans.

#### OTHER PUBLICATIONS

Seventeen releases have been written for the *Journal of the American Medical Association*, and 12 news and feature stories for the *STATE MEDICAL JOURNAL*. Articles have also been written each month for the *Connecticut Pharmacist*. A one page feature on development of the Veteran's Medical Care Plan was written for the December issue of *Re-Employment*, official publication of the Connecticut Veterans Re-Employment and Advisory Commission.

#### SPEAKERS BUREAU

Copies of a brochure outlining the services of this bureau were mailed to organizations throughout the state last August. Since then arrangements for 30 speakers to appear before these organizations have been made through this office by Dr. Grace Mooney. Approximately one half of these arrangements have been made for groups planning their programs for 1947. Only 16 physicians are involved in the 30 engagements planned. More requests were received from Parent-Teacher Associations than any other group, and most of these were for talks on child development.

#### CLIPPING SERVICE

Last September a New York clipping bureau was engaged, but this service proved too expensive for the results obtained and it was discontinued last month. A recently organized New Haven press clipping service has since been engaged.

#### PRESS COVERAGE

A system to provide newsmen with adequate facilities for coverage of any large meetings sponsored by the Society received its first try out last September during the three day Clinical Congress held in New Haven.

Press rooms, with adequate desk space, telephones, typewriters, paper, etc., were established at Yale's Strathcona Hall and the New Haven Hospital. Envelopes containing advance programs, biographical material concerning principal speakers, press badges, and luncheon tickets were distributed several days in advance for use by reporters assigned to the congress. It is planned to use this system of news coverage for all similar events.

#### MEDICAL ORGANIZATION STUDY

An important part of the public relations program has been the study of the organizational activities of the Society and the eight county medical associations. This was started last fall, when the annual meetings of all the county organizations were attended.

Several of the Society's principal committees have received attention directed toward the development of information suitable for press release. Committees which at present offer the best possibilities in this direction are those on Veterans Medical Care, Industrial Health, and Rural Health. Others will no doubt develop as the attention of the public is attracted toward other interests.

It was recently possible to attend the annual Conference

of Editors and Secretaries at the American Medical Association and to observe there the activities of the numerous departments of the national organization. Although the public relations program there is still in the formative stage, it was reasonably established that our Connecticut program is moving in the right direction. Mr. Charles Swart, the new executive assistant in charge of A.M.A. public relations, promised to visit our New Haven office soon after the first of the year. At that time problems of coordination with the national plan will be further studied.

Also during the Chicago conference, an interview was obtained with William W. Bauer, M.D., director of health education, concerning the use of radio in promoting the interests of medicine. He estimated the average cost of a 13 week sustaining program of one 15 minute period weekly at approximately \$1,500. This results, not from any charge for time on the air, but for scripts, rehearsals, recordings, etc. In a sponsored program the sponsor would, of course, bear all these costs, he explained.

#### OTHER ORGANIZATIONS

Study and development of relations with other organizations has proceeded quite rapidly. Two chief developments have been an assignment to coordinate the veteran's medical care program with the Veterans Administration and to aid in the educational program of the newly organized Connecticut Rehabilitation Association. The officers of the Connecticut Cancer Society, the Tuberculosis Association, Pharmaceutical Association, and other health and social agencies have been contacted and relationships developed for cooperative effort in future programs. A number of meetings held by these organizations have been attended in several sections of the state, both to report the events for the *JOURNAL* and to meet the officers of the various groups.

#### PROJECTS

Several projects are now being developed to strengthen relations by deed as well as word. One of these is a service for newspapers. It comprises a collection of reprints of authoritative recent articles on health and medical care. Contained in a specially prepared manila file envelope, the initial mailing to editors will include a dozen pieces of significant literature. As additional material of this type becomes available, reprints will be secured and mailed for inclusion in this file. Its purpose is to furnish editorial and news writers with accurate facts concerning medical care.

Another project now receiving consideration concerns the further development of meetings of our Industrial Health Committee with management. It is felt that such meetings can be appropriately arranged through the public relations officials of larger industries, and that these will contribute to good will and mutual understanding. If this program proves feasible, it should assist in paving the way for the medical care plan for employee groups, the development of medical news in house organs, and the continued advancement of industrial medicine.

James G. Burch,  
Public Relations Director

Meeting adjourned at 8:30 P. M.



Doctor ---

INFORM YOUR PATIENTS !

WE CONNECTICUT PHYSICIANS BELIEVE THAT . . .

“The participation of VOLUNTEER PHILANTHROPIC HEALTH AGENCIES in a national health program should be encouraged, and the growth of such agencies, when properly administered, should be commended.”\*

*Volunteer philanthropic health agencies, such as the American Red Cross, the American Cancer Society, the National Tuberculosis Association, the National Foundation for Infantile Paralysis, Inc., and similar bodies have been developed to help control health menaces not taken care of by existing professional or governmental groups.*

Such agencies are a natural outgrowth of the system of Free Enterprise and Democracy. They are *the American way of life*, of sharing with and succoring the less fortunate. They have been of vast benefit to the American people.

WE CONNECTICUT PHYSICIANS BELIEVE THAT PROPERLY ADMINISTERED AND IN THEIR PROPER SPHERE OF ACTIVITY, VOLUNTEER PHILANTHROPIC HEALTH AGENCIES ARE AN IMPORTANT PART OF AN ADMIRABLE SYSTEM OF SHARING WITH EACH OTHER. MAY WE ALWAYS LIVE IN A SOCIETY WHICH PROVIDES EVERY ENCOURAGEMENT TO PROPERLY-DIRECTED, OPEN-HEARTED GENEROSITY OF MANKIND TOWARD FELLOW-BEINGS.

COMMON-SENSE HEALTH PROGRAM

Adopted Feb. 14, 1946 by the Trustees and the Council on Medical Service of the American Medical Association

- |   |   |
|---|---|
| <sup>1</sup> High Standard of Living  | <sup>2</sup> Preventive Medical Services    |
| <sup>3</sup> Adequate Maternity Care  | <sup>4</sup> Adequate Infant and Child Care |
| <sup>5</sup> Research In The Medical Sciences                               | <sup>6</sup> Widespread Health Education    |
| <sup>7</sup> Extension of Voluntary Prepaid Medical and Hospital Care Plans |   |
| <sup>8</sup> Health and Diagnostic Centers and Hospitals                    |   |
| <sup>9</sup> Adequate Medical and Hospital Care For The Veteran             |   |
| *Proper Development of National Philanthropic Health Agencies               |   |

See Connecticut State Medical Journal, <sup>1</sup>May, page 434; <sup>2</sup>June, page 497; <sup>3</sup>July, page 591; <sup>4</sup>August, page 677; <sup>5</sup>September, page 781; <sup>6</sup>October, page 863; <sup>7</sup>November, page 937; <sup>8</sup>December, page 1026; <sup>9</sup>January, 1947, page 52.

**If Free Enterprise in American Medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients.**

## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*  
EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven  
JOSEPH N. D'ESOP, New Haven

#### Dr. Couey Leaves Hartford Vets Center

Dr. Fred Couey, director of the Hartford Veterans Service Center since October 15, 1945, recently announced his resignation to accept a position as chief of instructional methods on the educational advisory staff at Air University, Montgomery, Ala.

Under his directorship, the Hartford Veterans Service Center grew from a referral center to an advisory, counseling and testing depot. Since its organization in 1944, it has aided almost 21,500 veterans on matters of business, education, housing, personal problems, employment and legal aid.

During the month of October, more than 2,000 veterans used the Center's facilities and 75 per cent of those interested in further schooling were admitted to educational institutions with the assistance of the staff.

Howard R. Stock, former assistant director, was recently elevated to the post of director of the Hartford Veterans Service Center to succeed Dr. Couey.

Mr. Stock, who has been connected with the Center since January, 1945, is a native of Sinsbury and a graduate of Weaver High School and Morse College in Hartford.

From 1941 to 1945, he served with the 242nd Infantry, 42nd (Rainbow) Division and was the Personnel Officer with a rank of 1st Lieutenant.

#### Veterans Administration Takes On Osteopaths

Veterans Administration has announced that arrangements have been completed for the appointment of doctors of osteopathy to serve in VA's Department of Medicine and Surgery.

The appointments will be made in compliance with Public Law 293, 79th Congress, which authorizes VA to hire doctors of osteopathy to work with veterans.

A doctor of osteopathy, to be eligible for appointment, must:

- (1) Be a citizen of the United States.
- (2) Hold a degree of doctor of osteopathy from a college or university recognized by VA.
- (3) Have completed an internship satisfactory to VA.
- (4) Hold a license to practice osteopathy in one of the states, territories or the District of Columbia.
- (5) Meet VA prescribed physical standards.

#### Surgeon General Designates New Commandant of Army Medical Library

Colonel Joseph H. McNinch, MC, has been designated Commandant of the Army Medical Library by the Surgeon General, succeeding Colonel Leon L. Gardner.

Colonel McNinch received his A.B. and M.D. degrees from Ohio State University and went directly into Army service. His assignments have included tours of duty at the Army Medical School, the Army Medical Museum and the Medical Statistics Division of The Office of The Surgeon General. During the war he served on the staff of Major General Paul Hawley, chief surgeon of the European Theatre of Operations. Upon his return he assumed the position of chief of the Historical Division, SGO, where he is compiling the History of the Medical Department in World War II.

Since 1936 Colonel McNinch has made his home in Washington, D. C.

#### Fee-Basis Physicians

Fee-basis applications have recently been mailed by the Veterans Administration to all members of the Society. Physicians who have not received these should notify the Medical Section, Veterans Administration, 95 Pearl Street, Hartford.



## DEVELOPMENTS IN THE CARE OF THE CHRONIC SICK IN CONNECTICUT

A. NOWELL CREADICK, M.D., *New Haven* and JOSEPH H. HOWARD, M.D., *Bridgeport*

THE MEDICAL members of the Commission on the Care of the Chronically Ill are anxious to keep the profession apprised of the trends in social welfare that may affect medical practice. There is no attempt intended to express the final decisions of the Commission nor the General Assembly, but it is proper to outline the facts that may ultimately influence those decisions. Physicians are always called upon to solve social and economic problems as well as the purely medical, and must be acquainted with the agencies available for help. In Connecticut, care of the indigent and chronically incapacitated has always devolved upon the town and it is only lately that the State and Federal Government have found means to increase this aid. Such patients as were a risk to their fellow citizens were segregated in special institutions; such as those for mental cases, tuberculosis, the blind, etc. The State assumed the charge for those cases not citizens of the town in which their incapacity became apparent. The remaining cases were housed usually in a "poor house" or "poor farm." Despite the fact that each town was required to provide medical care, the "poor house" became a soulless custodial institution with a mixed population of inebriates, derelicts and "hopeless" cases for whom little remedial care was given. Dependent children were early cared for separately. Recent efforts for improvement of the care of the indigent and chronically ill were based on the premise that the condition was economic in origin and financial aid was contributed by government at all levels, administered by the Commissioner of Public Welfare through Old Age Assistance. In 1943 the Commissioner was authorized to pay for medical services and convalescent care. That efficient program now cares for about 15,000 cases and expends over eight million dollars per year of which one and one half million for medical and nursing services. Thus the fact that the whole situation might be a medical problem has been recognized. At the same time a Division of the State Department of Health instituted care for mental cases through Mental Hygiene Clinics, and lately a division has been created to study Geriatrics. This Department also regulates and supervises the Chronic and Convalescent Homes. Meanwhile the total population of the State has increased slightly but the age group

has increased markedly. There are now over a quarter of a million of our people past sixty years of age and it is estimated that 51,000 are incapacitated. Despite the measures already taken to treat some of these cases, their number is increasing. The most critical demands put on the Commission were for more beds for long term care in hospitals or convalescent homes. Unless some active medical measures are taken to alleviate or postpone deterioration and incapacity, the increased demand for such beds will exceed our capacity to supply them. Such a situation puts the problem upon the medical profession. Many of these facts were brought out by the Report in 1943 of the Commission of which Dr. Barker was chairman and Dr. Hiscock, a member. In 1945 Dr. Heiser for the Public Welfare Council issued a Report to the General Assembly which showed the case load increasing and proposed a system of institutions across the State to meet the need. The Legislature in 1945 created our Commission to see if this aid might be provided through expansion of "existing institutions and agencies" and our report will soon be made to the present General Assembly.

The opinion and support of the medical members of the Commission has been accorded the following program:

1. A Central Institution for treatment of long term illnesses should be established and staffed by a full time director and by medical experts devoted to the study of cardio-reno-vascular disease, heart disease, cancer, arthritis, multiple sclerosis and other neurological diseases as well as the mild mental confusions.
2. Ample provisions must be created for annual physical examinations and ready transport of cases from one facility to another as need arises. These provisions must be available for pay, part pay and public charges.
3. Material increase in the chronic beds associated with state-aided general hospitals, supervised by their regular staffs and open to pay cases as well as State and town cases under the program administered by the Commissioner of Public Welfare.
4. Stimulation of the good fraternal and religious homes to increase their facilities.
5. Subsidy of five major plants across the State

containing both custodial and hospital wings.

It is understood that mere years are not the problem. Many past sixty are alert and active. During the war years industries found both men and women, customarily regarded as past hiring age, so methodical and accurate in their work that their daily output compared favorably with the younger worker whose output was greater but whose speed might be accompanied by less meticulous care. It is only when illness complicates the picture that incapacity results and this illness may begin at any age. Costs of serious prolonged illness soon result in cessation of earnings, consumption of savings, inability of family and friends to provide nursing care and finally public aid.

It is obvious that the self sufficient elderly persons should be housed only under the slightest supervision, in the surroundings and among the people to which they are accustomed and it is debateable whether any of these facilities need to be owned or operated by government at any level. The church homes, the fraternal homes and the private boarding homes are the character which should be supervised for fire risk and for simple rules of care. The critical medical problem is how this group can be examined periodically, advised as to diet, dental prosthesis and like advice and thus cared for in order to obviate or defer degeneration, to forestall the inroads of cancer or progressive neurological or psychotic diseases. There will always be a number of elderly persons who have no family or whose dispositions prevent boarding care at nursing homes who will be a responsibility of the town or State. The best social service opinion is that these cases should be clustered in small homes, in natural surroundings, and kept busy with occupational therapy. Segregated in large numbers, in an institutional atmosphere, and unoccupied in mind and body, they deteriorate. Medical service is provided for the town cases but it usually is palliative. Our hope is that a more comprehensive and long continued medical program might improve the condition of this group. This medical care can be provided locally on a fee-for-service basis by the physician chosen by the individual or, lacking such a choice, by a staff or panel chosen by the first selectman or welfare head. Cases now resident in the almshouses or poor farms are required by law to have an annual physical examination. If we could require this procedure for all State cases and recommend it for all Old Age Assistance cases and encourage others to follow

such a practice, it will involve considerable exactions on the regular medical profession especially those interested in general practice, internal medicine and metabolic diseases. If, however, the State Department of Health could raise the Tumor Clinics or establish general physical examination clinics in all State aided hospitals it would be simple for the practitioner to refer cases to such clinics where the routine laboratory and special tests could be done and the reports sent to the referring doctor. The latter's time would be conserved, the patient more promptly cared for and a more comprehensive report sent to the Public Welfare Council.

Where such cases need biopsy, examination, a metabolism study to get in sugar-balance, or a sympathectomy for high blood pressure the case should be referred to the nearby chronic wing of the State-aided hospital. As soon as the treatment was concluded the case would be sent back to his home, his boarding home, the chronic convalescent home if he needed slight nursing care or to the town home.

The Public Health Nursing Service should be increased so that a certain amount of supervision of the home and housekeeping of elderly patients could be maintained. Incipient illness is frequently observed by the visiting nurse and she has proven in the past to be most useful as a "case finder." She encourages the patient to go to his physician at once rather than wait until the condition is irreparable.

Hitherto, it has been customary to establish single or multiple institutions for special diseases in the State, sometimes at a distance from the home of the patient and usually isolated from urban areas. Of course better work can be done where a large number of similar cases can be collected but sometimes needs change and institutions must be put to "change of use." Up to date thinking requires use of existing facilities and their development or enlarging at strategic points along the centers of population and we have favored assistance to the town operated homes and hospitals of the better type such as Greenwich, Bridgeport, Hartford, later developing one in New Haven County and one in the Norwich area. Adjacent towns might be encouraged to place their cases in such places rather than maintain a small individual house or farm of their own. Improvements in medical care of chronic disease will necessitate research and the more elaborate must be begun in a well equipped central hospital. To secure good investigators and avoid laboratory duplication



this center should be near a large medical institution.

The legislature in 1945 realized that this problem had many possibilities of accomplishment and of error. The Commission they raised is continuing, the appointments running for four years. We realize that any suggested program can only be installed gradually and errors will be avoided if possible.

### Campaign to Combat Heart Disease

The initiation of a nationwide program of public education and information on diseases of the heart was announced recently by officials of the American Heart Association, Inc.

The program, according to Dr. Howard F. West, of Los Angeles, president of the association, will have as its prime purpose "the dissemination of educational information to the public in a broad effort to retard the rapid increase of heart disease throughout the nation.

"Fatalities ascribed to diseases of the heart," Dr. West said, "are greater than the total of the next five leading causes of death. It is essential, therefore, that the public know more about the significance of blood pressure, infections, over-weight, rheumatic fever, and other factors which contribute to various types of heart disease."

It is estimated that there are more than 4,000,000 people in the United States today who have heart disease. Diseases of the heart and blood vessels, including cerebral hemorrhage, accounted for 575,000 deaths in 1944. Fatalities from the five other leading causes in 1944 were as follows:

Cancer	171,000
Accidental deaths	95,000
Nephritis	92,000
Pneumonia	64,000
Tuberculosis	55,000

In addition to accounting for more fatalities than these five causes combined, heart diseases are responsible for an annual loss of more than 100,000,000 work days.

Officials of the American Heart Association state that the association's program will call for emphasis on educational work with schools, parent-teachers' associations and other groups concerned with children because of the importance of rheumatic fever and heart disease. According to recent surveys, this

scourge of children causes more than five times as many deaths as the combined total of deaths from infantile paralysis, scarlet fever, diphtheria, measles, meningitis, and whooping cough. It is a serious disease among adults, too, as illustrated by the estimated 40,000 veterans who acquired the disease during their recent military service.

The war forcibly dramatized the need for a national health program designed to retard the increase in heart disease cases. An estimated ten per cent of the men rejected by the U. S. Selective Service were disqualified because of cardio-vascular diseases (diseases of the heart and blood vessels). In a survey of a special sampling of 5,000 rejectees for cardio-vascular diseases in five major cities—Chicago, New York, Boston, Philadelphia, San Francisco—50 per cent had been disqualified because of rheumatic heart disease. The second greatest cause of rejection due to cardio-vascular diseases was hypertension (high blood pressure), which accounted for 25.6 per cent of the disqualifications.

The educational campaign of the American Heart Association will reach its climax during National Heart Week to begin on February 9, 1947, which includes St. Valentine's Day. It is expected that all branches of medicine, pharmacy, insurance, industry and many other groups interested in health and public welfare will cooperate fully.

Supporting and cooperating groups will include the following national organizations which comprise the American Council on Rheumatic Fever of the American Heart Association: American Academy of Pediatrics, American Association of Medical Social Workers, American College of Physicians, American Hospital Association, American Medical Association, American Nurses Association, American Public Health Association, American Rheumatism Association, American School Health Association, National Organization for Public Health Nursing, National Society for Crippled Children and Adults. The collaboration of the United States Public Health Service, National Tuberculosis Association and others is expected.

Local Heart Associations and affiliated groups in such cities as New York, Washington, Chicago, Boston, etc., will assist in the national campaign.

The list of directors of the American Heart Association includes H. M. Marvin, M.D., New Haven.

## SPECIAL NOTICES

### YALE UNIVERSITY DEPARTMENT OF HEALTH DIVISION OF PSYCHIATRY Lectures in Psychiatry — Part II

February 11, 1947

Thomas French, M.D. (Chicago Psychoanalytic Institute, Chicago, Illinois)

"The Principle of Naive Interpretation"

February 25, 1947

Erich Lindemann, M.D. (Harvard Medical School, Boston, Massachusetts)

"Some Psychotherapeutic Problems Encountered in the Psychiatric Management of Ulcerative Colitis"

March 11, 1947

Rudolph Loewenstein, M.D. (New York Psychoanalytic Institute, New York, New York)

"Trends in Psychoanalysis"

April 15, 1947

Sandor Rado, M.D. (Columbia University College of Physicians and Surgeons, New York, New York)

"Emergency Function and Neurotic Behavior"

April 29, 1947

Spafford Ackerly, M.D. (University of Louisville School of Medicine, Louisville, Kentucky)

"Adolescence"

All lectures will be held on Tuesdays at 7:15 P. M. at 201 William L. Harkness Hall.

### 20TH ANNUAL MEETING, NATIONAL CONFERENCE ON MEDICAL SERVICE

Sunday, February 9, 1947  
Palmer House, Chicago, Illinois

#### PROGRAM

- 9:00 Registration, Red Lacquer Room, fourth floor.
- 9:30 Call to order and Address of the President  
Cleon A. Nafe, Indianapolis.
- 9:50 The Eightieth Congress  
Joseph S. Lawrence, Washington, D. C.
- 10:10 The Operation of Public Law 725: The National Hospital Construction Act  
Herman E. Hilleboe, United States Public Health Service, Washington, D. C.
- 10:40 Discussion period.
- 11:00 Veterans Care: Where Do We Go From Here?  
Paul B. Magnuson, Veterans Administration, Washington, D. C.
- 11:30 Medical Cooperatives.  
Mr. L. S. Kleinschmidt, Chicago.
- 11:50 Developments in the Council of Medical Service.  
Mr. Thomas A. Hendricks, Chicago.

12:15 Luncheon.

Warning: S-Curves Ahead

Mr. Clarence A. Jackson, Executive Vice-President Indiana State Chamber of Commerce, Chairman of the Social Security Committee of State Chambers of Commerce and member of the United States Chamber of Commerce Social Security Committee

2:15 Open Forum: Modern Influences in Medical Practice: Undergraduate Medical Education; Trends towards Specialization; General Practitioners in Hospitals; Hospital Staff Organization.

Moderator: Creighton Barker, New Haven.

Duncan W. Clark, Associate Dean, Long Island College of Medicine.

B. R. Kirklin, Secretary, Advisory Board for Medical Specialties, Rochester, Minnesota.

Leo G. Christian, Vice-Chief of Staff, St. Lawrence Hospital, Lansing, Michigan.

Thomas P. Murdock, Chief of Staff, Meriden Hospital, Meriden, Connecticut.

### POSTGRADUATE SEMINAR IN RADIOLOGY

The second annual Philadelphia postgraduate seminar in radiology will be held next spring, March 30 to April 4. The course is jointly sponsored by the Commission on Education of the American College of Radiology and the Philadelphia Roentgen Ray Society. Preliminary details have been announced by Dr. Barton R. Young, chairman of the special committee of the Philadelphia Roentgen Ray Society. Dr. Paul C. Swenson, Philadelphia, has been appointed director of lecture sessions. Dr. Calvin L. Stewart is secretary.

The Committee on Selections for the postgraduate course has been appointed and is ready to receive applications. Radiologists desiring to enroll in the course can obtain application forms by writing to the headquarters office of the College. As was the case last year, the course will be limited to one hundred registrants, with first preference being given to members of the American College of Radiology who served in World War II.

The success of the first course, conducted last February, was universally acclaimed by those who enrolled. Members of the College desiring to take the course are urged to write for application forms promptly. The tuition fee will be \$50.

Registration will take place on Sunday, March 30, in the Philadelphia County Medical Society Building, where all lectures will be conducted. Sessions will be held daily from 9 A. M. to 5 P. M. through Friday, April 4. Luncheon will be served each day without extra charge in the same building.

Hotel reservations will be made through a central agency for all matriculants as soon as they are selected.

The course will end with a banquet at which Dr. E. H. Skinner, president of the College, will be the principal speaker.



ANNOUNCEMENT OF  
A POSTGRADUATE COURSE ON INDUSTRIAL MEDICINE  
TO BE GIVEN UNDER THE AUSPICES OF THE  
YALE INSTITUTE OF OCCUPATIONAL MEDICINE AND HYGIENE  
AT THE  
YALE UNIVERSITY SCHOOL OF MEDICINE  
FEBRUARY 4—APRIL 8, 1947

Sessions will be held each week on Tuesdays from 4:00 to 5:30 P. M., Brady Amphitheatre. Entrance at 310 Cedar Street.

This course is open without charge, to all physicians, particularly those engaged in full-time or part-time industrial practice.

Inquiries and reservations should be addressed to Dr. R. F. Buchan, Yale Institute of Occupational Medicine and Hygiene, 310 Cedar Street, New Haven, Connecticut.

**FEBRUARY 4—COMMONLY ENCOUNTERED TOXICOLOGICAL PROBLEMS**

Principal Speaker—Dr. John H. Foulger, director, Haskell Laboratory of Industrial Toxicology, Wilmington, Delaware

Chairman—Dr. Alice Hamilton, formerly assistant professor of Industrial Medicine, Harvard Medical School; formerly special investigator of Poisonous Industries for the U. S. Bureau of Labor Statistics; author "Industrial Poisons in the U. S." and "Industrial Toxicology"

**FEBRUARY 11—INDUSTRIAL HYGIENE: ITS MODERN CONCEPT**

Principal Speakers—Dr. Albert S. Gray, director, Bureau of Industrial Hygiene, Connecticut State Department of Health

Mr. Allan Coleman, chief industrial hygienist, Bureau of Industrial Hygiene, Connecticut State Department of Health

Chairman—Dr. Ronald F. Buchan, Clinical Director, Institute of Occupational Medicine and Hygiene, Yale University School of Medicine

**FEBRUARY 18—DIAGNOSIS AND THERAPY OF INDUSTRIAL DERMATOSES**

Principal Speaker—Dr. Louis Tulipan, clinical professor of Dermatology and Syphilology, New York University College of Medicine; co-author "Occupational Disease of the Skin" (Schwartz and Tulipan)

Chairman—Dr. M. J. Strauss, clinical professor of dermatology, Yale University Medical School

**FEBRUARY 25—THE HAND IN INDUSTRY**

Principal Speaker—Dr. Sumner L. Koch, F.A.C.S., Associate Professor of Surgery, Northwestern University Medical School; Diplomate, American Board of Surgery; Attending Surgeon Cook County Hospital, Chicago; Attending Surgeon Passavant Hospital, Chicago; Member—Subcommittee—Infected Wounds and Burns, National Research Council

Chairman—Dr. Samuel Harvey, professor of Surgery, Yale University Medical School

**MARCH 4—THE INDUSTRIAL PHYSICIAN'S RESPONSIBILITY UNDER THE COMPENSATION LAW**

Principal Speaker—Mr. Louis Sachs, Compensation Commissioner of New Haven

Chairman—Professor Harry Shulman, professor of Law, Yale University Law School

**MARCH 11—PATTERN FOR DIAGNOSIS OF BEHAVIOR IN INDUSTRIAL RELATIONS**

Principal Speaker—Dr. E. Wight Bakke, director, Labor and Management Center, Yale University

Chairman—Dr. Warren T. Brown, assistant professor of Mental Hygiene, Psychiatry and Mental Hygiene, department of Psychiatry and Mental Hygiene, Yale University Medical School

## MARCH 18—TOXIC AND NUISANCE DUSTS IN INDUSTRY

Principal Speaker—Dr. Theodore F. Hatch, Head, Membership Relations, Industrial Hygiene Foundation of America, Inc., Pittsburgh, Pennsylvania; co-author "Industrial Dust, Hygienic Significance, Measurement and Control" (Drinker and Hatch)

Chairman—Dr. Dudley A. Irwin, medical director Aluminum Company of America, Pittsburgh, Pennsylvania

## MARCH 25—VISION IN INDUSTRY

Principal Speaker—Dr. Hedwig S. Kuhn, Diplomate, American Board of Ophthalmology and Otolaryngology; Staff Member St. Margaret's Hospital, Hammond, Ind.; Staff Member St. Catherine's Hospital, East Chicago; Member, Association for Research in Ophthalmology; Author—"Industrial Ophthalmology"

Chairman—Dr. Eugene M. Blake, Clinical Professor of Ophthalmology, Yale University Medical School

## APRIL 1—RADIOACTIVITY, HEALTH AND SAFETY

Principal Speaker—Dr. Stafford Warren, formerly Colonel, U. S. Army Medical Corps; formerly medical director, Manhattan Project, Corps of Engineers and now consultant to that project; professor of Radiology, School of Medicine and Dentistry, University of Rochester, Rochester, New York

Chairman—Dr. Averill A. Liebow, assistant clinical professor of Pathology, Yale University Medical School

## APRIL 8—FACILITIES FOR REHABILITATION OF THE INJURED AND PHYSICALLY HANDICAPPED WORKER

Principal Speaker—Dr. Howard A. Rusk, formerly chief of Rehabilitation Service, U. S. Army Air Force; director, Department of Rehabilitation and Physical Medicine, New York University; associate editor, *New York Times*

Chairman—Dr. A. J. Lanza, associate medical director, Metropolitan Life Insurance Company, New York City

## Medical Skim Milk Under British Medical Service Act

(From a letter—reprinted from *British Medical Journal*)

It is a truism today that medical manpower is inadequate for the decent care of our population. All parties are pledged to make an equal distribution of what is available regardless of the patient's finances. When a vital commodity, e.g., milk, is in short supply but is rationed equally among us we are satisfied. If, for comparison, we express medical services in terms of doctor-hours, which is mainly what they consist of, then the Act falls short of the objective. The bill will mean, so to speak, skim milk for the masses while the cream will go to the private patient; and more patients who can pay will resort increasingly to doctors privately and so procure less meagre doctor-hours. It will be galling for the man-in-the-street to be taxed for what amounts to skim medical milk for the next ten years.

Under the Act payment will be at a fixed rate and virtually automatic owing to the scarcity of doctors. This stultifies effort, for the average doctor is only human and puts forth the extra effort when there is corresponding reward. Half the good the patient gets out of his doctor is in service of an intangible

kind not susceptible of supervision; and the amount of care he gives, not the fittings and style of his surgery, is what counts most. When patients are too numerous for decent handling, then those among his clientele who are willing to pay will, by reason of the private contract, command that personal touch which we all covet. The Act will perpetuate the present panel *versus* private division of medical service which has led to the disrepute of the profession. The distinction is disconcerting and demoralizing to the young doctor who at hospital learns how to *extinguish* between the victims of it. That is the mainspring of professional life, and proficiency has been furthered by an atmosphere of competition which fosters ambition, enterprise, and effort. The guardians of health cannot afford to ignore healthy rivalry which bred the renowned English family doctor; and loyalty to the profession forbids acquiescence in conditions calculated to lower our standard. Parliament may be satisfied, but we shall not be until medical service of one grade, equal in quality and quantity, is meted out to all according to the disease, not the purse, of the patient. To attain service of the best quality a competitive element must be conspicuous in the scheme. In these vital principles the bill largely fails.



## EXAMINATIONS FOR U. S. PUBLIC HEALTH SERVICE

Competitive examinations will be held early in 1947 for appointment to the Regular Corps of the United States Public Health Service, according to a recent announcement by Dr. Thomas Parran, Surgeon General. Seventy-five vacancies exist in grades of Assistant and Senior Assistant Scientist.

Written examinations, covering each candidate's particular field of science, as well as related fields, will be held April 14 and 15 at places mutually convenient to the applicant and the Service. Oral examinations will be held during the period February 13-April 9 in thirty cities, strategically located throughout the United States.

Commissions are available to scientists trained in any of the following fields: bacteriology, mycology, parasitology, entomology, malacology, biology, chemistry, physiology, physics, statistics (mathematical, demographic, etc.), psychologists, and milk and food specialists. Assignments will be in line with the individual's demonstrated ability and experience.

An applicant for the grade of Assistant Scientist must be a citizen of the United States, have seven years of educational and professional training or experience, possess a certificate or diploma from an institution of recognized standing, and be able to pass a physical examination given by a medical officer of the United States Public Health Service. The same requirements, plus an additional four years of training or experience, apply to those seeking the grade of Senior Assistant Scientist.

Commissioned Officers in the Regular Corps enjoy the same benefits and privileges as do officers of the Army, Navy, or Marine Corps. The grade of Assistant Scientists is equal to that of First Lieutenant in the Army. Annual pay, with allowances for dependents, is \$3,811. A Senior Assistant Scientist ranks with a Captain of the Army and draws, with allowances for dependents, \$4,351 a year.

United States Public Health Service Officers are entitled to full medical care and hospitalization for themselves and their families, including disability retirement at three-fourth's base pay. They receive thirty days annual leave with pay. Periodic promotions are based upon length of service and merit. The retirement age is 64.

Application forms and additional information may be obtained by writing the Surgeon General, United States Public Health Service, Washington 25, D. C.

Local places and dates of oral examination: Boston, Mass.—Marine Hospital, 77 Warren Street (Brighton), April 1. New York, New York—USPHS District No. 1, Sub-Treas. Bldg., 15 Pine St., March 31.

## EXAMINATION OF NURSES FOR U. S. PUBLIC HEALTH SERVICE

Examinations for the appointment of nurses to the first three grades of the Regular Commissioned Corps of the U. S. Public Health Service will be given during February and March in 21 cities throughout the Nation.

Positions are now open in Marine Hospitals of the Service for nurses in the grades of Junior Assistant Nurse

Officer, comparable to the rank of Army second Lieutenant; Assistant Nurse Officer (first lieutenant); and Senior Assistant Nurse Officer (captain). Candidates will be judged on the basis of professional, general, and physical fitness. Positions are also open for nurses in public health nursing and for certain special projects of the Public Health Service.

The examinations for *Junior Assistant Nurse Officer* may be taken by any registered nurse who is a citizen of the United States and has a diploma from a state-accredited school of nursing connected with a hospital maintaining a daily average census of not less than 50 patients and offering experience in medicine, surgery, pediatrics and obstetrics. She must also be at least 18 years of age and have graduated from an accredited high school or possess equivalent college entrance requirements, and present evidence of general suitability including professional and personal fitness. Candidates with degrees will be given preference.

Senior students in schools of nursing may take the examination for *Junior Assistant Nurse Officer* if, upon graduation and registration, they fulfill the above requirements. No action will be taken regarding appointment until evidence of registration is presented.

In addition to the above named qualifications, candidates for *Assistant Nurse Officer* must have been out of high school at least seven years (with intervening time having been devoted to educational and professional training experience) and they must hold an academic degree, or have served at least four years in either the Public Health Service, the Army or Navy Nurse Corps.

A *Senior Assistant Nurse Officer* must have completed at least four additional years of postgraduate training or experience, or a total of 11 years of postgraduate training and experience since graduation from high school.

Salaries in the Commissioned Nurse Corps are the same as for officers of comparable rank in the Army and Navy. For officers without dependents the scale is: annual pay and allowance for Junior Assistant Nurse Officer, \$2,955.50; Assistant Nurse Officer, \$3,375.50; and Senior Assistant Nurse Officer, \$3,915.50. If quarters are provided the following annual deductions are made: Junior Assistant Nurse Officer—\$540; Assistant Nurse Officer—\$720; and Senior Assistant Nurse Officer—\$900.

Although appointments are permanent, officers may resign at any time except during a war emergency. The wearing of uniforms is now discontinued except on certain specified stations.

Oral examinations will be held at 9:00 A. M. at the several places listed below on the dates shown. The written examination will be held on April 14 and 15 in designated places which will be announced to the candidate at the time of the oral examination. If possible, physical examinations should be taken in the nearest Public Health Service facility prior to the oral examination. Appointments may be made directly with the medical officer in charge. If it is not possible to take the physical examinations prior to the oral examination arrangements may be made at the time of the interview.

Places and dates of Oral examinations in the East:

Boston, Mass.—Marine Hospital, 77 Warren Street, February 24.

New York, New York—Relief Station, 67 Hudson Street, February 25-26.

Pittsburgh, Pennsylvania—Marine Hospital, 40 St. & Penn Ave., March 3.

Rochester, New York—University of Rochester, February 28.

Syracuse, New York—University of Syracuse, February 27.

Washington, D. C.—USPHS Dispensary, 4th & D St. S. W., April 2.

## POSTGRADUATE COURSE IN RADIOLOGY

One hundred radiologists will be selected to attend the postgraduate courses in radiology to be conducted March 30 through April 4 in Philadelphia by the American College of Radiology. Preference will be given to radiologists who served in World War II. Second preference will be given to qualified applicants who were unable to obtain admission to last year's course in Philadelphia. The course is sponsored jointly by the American College of Radiology and the Philadelphia Roentgen Ray Society.

Because of the popularity of the course given in Philadelphia last year, many radiologists were unable to be enrolled. Numerous requests for a second similar course have prompted the committee to sponsor it again this year.

There are two main considerations which have impelled the committee to undertake this program:

Although national and local scientific societies in the specialty of radiology have maintained a consistently high standard in their regular meetings, numerous inquiries have indicated an obvious need for intensive courses of a more academic nature. Also, veteran medical officers have been felt to be in need of an intensive review before returning to private practice. Many of these men were denied the opportunity for normal clinical practice or study which would keep them abreast of the rapid progress in the specialty of radiology.

Some of the subjects to be studied are: Certain neoplastic and inflammatory diseases, Carcinoma of the head and neck, dosage calculation and tumor sensitivity in radiation therapy, carcinoma of the breast, blood and hemopoetic diseases, carcinoma of the genital and urinary tract, benign and malignant diseases of the skin.

## GLAUCOMA PRIZE AGAIN OFFERED

The National Society for the Prevention of Blindness announces that papers submitted for the glaucoma prize of \$500 offered in 1944 did not conform to the criteria set up by the ophthalmological committee selected to award the prize. Therefore, the prize is again offered for the most valuable original paper adding to existing knowledge about the diagnosis of early glaucoma or the medical treatment of non-congestive glaucoma. The criteria may be secured

by writing to the National Society for the Prevention of Blindness, 1790 Broadway, New York 19, N. Y.

Papers may be presented by any practicing ophthalmologist of the Western Hemisphere and may be written in English, French, German, Italian, Spanish or Portuguese. Those written in any of the last four languages should be accompanied by a summary in English. Closing date for receipt of papers is December, 1947.

The award will be made by the Society with the guidance of an ophthalmological committee composed of Doctors John N. Evans, chairman; Frank C. Keil, Daniel B. Kirby, John M. McLean, R. Townley Paton, Algernon B. Reese, Bernard Samuels, Kaufman Schlivek, Willis S. Knighton, Manuel Uribe Troncoso, David H. Webster.

## FELLOWSHIPS FOR PHYSICIANS AND ENGINEERS

Announcement is made by Surgeon General Thomas Parran of the U. S. Public Health Service that applications for Fellowships in postgraduate public health training for physicians and engineers for the school year beginning in the fall of 1947 will be received at any time prior to May 1, 1947.

The Fellowships are made possible by a grant of \$228,400 from the National Foundation for Infantile Paralysis through funds contributed to its March of Dimes. Fifty-three students were awarded Fellowships for the school year beginning in September 1946.

The Fellowships provide an academic year's graduate training of approximately nine months in an accredited school of public health or an acceptable school of sanitary engineering followed by three months of field training, and are open to men and women, citizens of the United States, under 45 years of age. Physician applicants must have completed at least a year's internship. Engineering graduates with a Bachelor's or higher degree in Sanitary, Civil or Chemical Engineering are eligible; and those with other engineering degrees who have had experience in the public health or sanitary engineering field may also submit applications. The Fellowships are administered by the Committee on Training of Public Health Personnel, which consists of representatives of schools of public health, the State and Territorial Health Officers, the American Public Health Association, and the U. S. Public Health Service.

The specific purpose of the Fellowships is to aid in the recruitment of trained health officers, directors of special services, and engineers to help fill hundreds of vacancies existing in State and local health departments throughout the country. The Fellowships are intended for newcomers to the public health field, and are not open to employees of State and local health departments, for whom Federal grant-in-aid funds are already available to the States.

Applicants for Fellowships may secure further details by writing to the Surgeon General, U. S. Public Health Service, 19th and Constitution Avenue, N. W., Washington 25, D. C., Attention Public Health Training.



## KR, The New Cancer Treatment

From the Soviet Union comes the news of the manufacture of a bio-preparation KR which dissolves the cancer tumor without affecting the healthy tissue of the organism. KR is named for the initials of its creators, two Soviet scientists, Nina Klyueva and Georgi Roskin. It was first tested on humans one year ago after years of experimental work with cancerous mice. Clinical observations showed that while KR had little effect in cases of cancer of the skin, it was highly effective in cancer of the throat, of the cervix uteri and of the breast.

Twenty years ago Professor Georgi Roskin of the Moscow State University set himself the task of finding a living organism capable of fighting the cancer cells. He based his research on the confirmed theory of the antagonism existing between living organisms in their struggle for existence.

As a result of many years of experimental work, his attention was drawn by the *trypanosoma kruzzi*, a one-cell animal and carrier of a disease mortal to man and beasts. Further research proved that the trypanosoma, on being introduced into the organism of a mouse suffering from cancer, penetrated to the tumor and multiplied, devouring the cancer cells.

In 1939 Georgi Roskin handed over his trypanosoma culture to the outstanding Soviet scholar, Nina Klyueva, now his wife. Experimental research in the fields of microbiology of intestinal infections, the changeability of bacteria and the microbiology and pathogenesis of cholera had given Nina Klyueva fame as a theoretician.

On receiving the trypanosoma culture, Nina Klyueva commenced experiments on the creation of a stable and concentrated preparation. The war somewhat delayed her work, which she completed this year, having experimented on 13 thousand mice with brilliant results. In 85 per cent of the first group of one hundred mice the living culture of the trypanosoma completely destroyed the cancer cells. However, the living trypanosoma, having devoured the cancer cells, began to destroy the animal's organism.

This obstacle was subsequently overcome, however, as the research and experiments proceeded.

Nina Klyueva succeeded in producing a medicinal preparation from dead trypanosoma, which retained the ability of the living trypanosoma to collect in the cancer tumors. Under the action of the KR preparation, the cancer disintegrates, giving place to fresh, healthy tissues.

## Scientists Named to Direct New Studies On Vitamins

An advisory committee of eight scientists has been appointed by the National Vitamin Foundation, Inc., to assist Dr. Robert Stanley Goodhart, scientific director, in the formulation of an overall research program on vitamins and to approve specific investigations to be conducted through grants-in-aid to various established institutions, continuing three such projects already under way. The Foundation replaces the Institute for Vitamin Research organized in 1944, and has established headquarters under Dr. Goodhart at 150 Broadway, New York.

In announcing the appointments and the Foundation's new name and goals, Dr. Theodore G. Klumpp, chairman of the Foundation's board of governors, stated the vitamin research program would be broad in scope "to permit the support of diverse projects likely to furnish information needed to fill in serious gaps in our knowledge of nutrition." Members of the committee who have accepted to serve the Foundation are:

Dr. Otto A. Bessey, The Public Health Research Institute of the City of New York, Inc.; Dr. George R. Cowgill, Yale University, School of Medicine; Dr. Norman Jolliffe, The Nutrition Clinic of the Department of Health of the City of New York; Dr. H. D. Kruse, Milbank Memorial Fund; Dr. Carl V. Moore, Washington University, School of Medicine; Dr. Severo Ochoa, New York University, College of Medicine; Dr. W. H. Sebrell, The National Institute of Health; and Dr. Frederick F. Tisdall, University of Toronto.

"The purpose of the Scientific Advisory Committee is to safeguard the quality of the Foundation's research program and to help assure its operation in the public interest" Dr. Klumpp said. "The Board of Governors believes the newly appointed committee to be a harbinger of a valuable and productive research program."

Under grants totalling \$11,000, the three investigations already in progress in which the Foundation is interested were announced by the board of governors as:

A nutritional survey of the school children of Burlington, Vt., being conducted under the direction of Dr. Harold B. Pierce, professor of biochemistry, College of Medicine, University of Vermont, to which the Foundation has granted \$4,000 for one year to enable the university to employ a clinical director.

Investigations of the role of folic acid in leukemia, being made by Dr. A. D. Welch, professor of pharmacology, Western Reserve University, and associates, to whom the Foundation has granted \$4,000 for one year.

Quantitative studies of the effects of nutrition upon the susceptibility of mice to anaphylactic shock, being conducted by Dr. Frederick J. Moore of the Department of Experimental Medicine, University of Southern California, School of Medicine receiving a grant of \$3,000 for one year. This work is planned as a first step in a long term program to identify the fundamental metabolic systems involved in anaphylaxis, allergy and immunity.

In addition to these grants-in-aid, which are to be made ordinarily by the Foundation on January 1 and July 1 of each year, a grant of \$1,000 was made to the New York City Food and Nutrition Committee for a permanent exhibit on nutrition. This exhibit was placed on public display in Rockefeller Center during June of this year and is between public exhibits at the New York City Food and Nutrition Center, 125 Worth Street.

DEATH RATE DROPS IN 1945

Fewer deaths occurred in the United States in 1945 than in either of the two preceding war years, according to figures released today by the U. S. Public Health Service. A total of 1,401,719 deaths were reported in the United States in 1945, as compared with 1,411,338 in 1944, 1,459,544 in 1943 and 1,385,187 in 1942.

In the first 10 months of 1946 there were an estimated 1,162,000 deaths in the United States, as compared with 1,144,273 in the first 10 months of 1945. All figures are for the continental United States and exclude deaths among the armed forces overseas.

Deaths from the major infectious diseases declined to new lows in 1945. The year set a record low for pneumonia and influenza. The total of 68,386 deaths from these respiratory causes was 8.2 per cent less than the previous minimum of 74,532 deaths in 1942 and 16.4 per cent less than the number reported for 1944.

Tuberculosis continued its decline in 1945. There were 52,916 deaths from this cause in the United States in 1945, 3.3 per cent less than the number in 1944 and fewer than in any previous year.

Heart disease, cancer, and intracranial lesions strengthened their positions at the head of the list of leading causes of death. Heart disease deaths accounted for 30.3 per cent of the reported deaths in 1945 as compared with 29.6 in 1944. Cancer, the second leading cause of death, claimed 12.7 per cent of the total as compared with 12.1 in 1944. The third leading cause of death, intracranial lesions of vascular origin, was responsible for 9.2 per cent of all deaths in 1945 as compared with 8.8 per cent in 1944.

An increase in motor vehicle accident deaths from 24,282 in 1944 to 28,076 in 1945 overbalanced a decrease of 3,113 in the number of deaths from other accidental causes. All accidental causes accounted for 95,918 deaths in 1945 as compared with 95,237 in 1944. The greater part of the increase in the motor vehicle accident death rate occurred in the second half of 1945 after gasoline rationing had come to an end.

The ten causes of death which are found in the lead in 1945 are those which headed the list in the pre-war period 1939-1941. With the exception of motor vehicle accidents, the ten causes rank in 1945 in the same order of importance as in the period 1939-1941. Due chiefly to wartime restrictions on driving, motor vehicle accidents dropped from eighth place as a cause of death in 1939-1941 to tenth place in 1942.

The ten leading causes of death in the United States are listed in table 1 attached. Tables 2 and 3 give the number of deaths and death rates for selected causes for the United States in 1944 and 1945.

TABLE I  
TEN LEADING CAUSES OF DEATH: UNITED STATES  
1944 AND 1945

CAUSE OF DEATH	NUMBER OF DEATHS		PER CENT OF ALL CAUSES	
	1945	1944	1945	1944
All causes .....	1,401,719	1,411,338	100.00	100.00
1. Diseases of the heart.....	424,328	418,062	30.3	29.6
2. Cancer and other malignant tumors .....	177,464	171,171	12.7	12.1
3. Intracranial lesions of vascular origin .....	129,144	124,250	9.2	8.8
4. Nephritis .....	88,078	91,687	6.3	6.5
5. Pneumonia (all forms) and influenza .....	68,386	81,804	4.9	5.8
6. Accidents excluding motor vehicle accidents .....	67,842	70,955	4.8	5.0
7. Tuberculosis (all forms) .....	52,916	54,731	3.8	3.9
8. Diabetes mellitus .....	35,160	34,948	2.5	2.5
9. Premature birth .....	31,614	33,120	2.3	2.3
10. Motor vehicle accidents ..	28,076	24,282	2.0	1.7

New Drug for Treatment of Hypertension

The U. S. Department of Agriculture announced recently that rutin, a drug with medical values undetected for more than a century, is ready for full scale production for the first time and enough to meet present medical needs in treating fragile and weakened capillaries will be available this year.

Commercial manufacture of rutin, a bright yellow non toxic powder, has been made possible by the discovery by the Bureau of Agricultural and Industrial Chemistry that the green buckwheat plant



is an economical source. The search for a plant yielding rutin has been carried on at the Bureau's Eastern Regional Research Laboratory over the past two years, and the findings indicate that the need for rutin, including its likely use in human nutrition, may take as much as 10 per cent of the pre war buckwheat acreage.

According to clinical observations at the Medical School of the University of Pennsylvania, rutin is effective in the treatment of conditions arising from high blood pressure associated with increased capillary fragility. Bursting of weakened blood vessels causes small hemorrhages which may result, when the rupture occurs in the eye or brain, in blindness or apoplexy.

Research indicates also that rutin, a glucoside, may have equally unsuspected nutritional values. Further investigation of the nutritional uses is expected, but the studies point to the opinion that rutin could serve the circulatory system in a manner resembling the action of Vitamin C in the growth and hardness of teeth and bones.

Buckwheat has proved superior to the other plants that have been found to contain the drug. Flue-cured tobacco leaves offered a fair yield, while the familiar garden shrub, hydrangea "P.G.," one of many other tested sources, indicated scant possibility of commercially successful extraction. Buckwheat superseded tobacco leaves as a likely commercial source when the plant was found to contain 8 to 20 times as much rutin and to cost only a fraction of the price.

The combined superiority of a higher yield and a lower cost, according to USDA scientists, is such that "\$10 worth of buckwheat will produce as much rutin as \$1,000 worth of tobacco."

Dr. Percy A. Wells, director of the Eastern laboratory at Wyndmoor, Pa., forecast that 1,300,000 pounds of rutin will be needed annually "to meet both the medicinal and nutritional requirements in this country." However, he estimated 1946 medical needs at 10,000 pounds.

As the buckwheat plant averages 4 per cent rutin, Dr. Wells estimates that 50,000 acres of buckwheat plantings will be required each year to supply the drug. Buckwheat harvestings averaged 424,000 acres a year from 1932 to 1941, inclusive, according to USDA statistics, and the demand for rutin is expected to exceed 10 per cent of the average pre war harvested acreage.

The director pointed out that, as the crop is harvested five weeks after the seed has sprouted, when the rutin yield is highest, instead of when the grain has ripened, special cuttings are required and producers supplying the plant for rutin could grow more than one crop a year. Buckwheat grain, the source of the flour so well liked in buckwheat cakes, is totally lacking in rutin, and the cutting takes place before the grain has matured. The substance is found mainly in the leaves and blossoms of the plant, with but little in the stems.

Although rutin was first isolated over a century ago, its medicinal use was not revealed until Dr. James F. Couch of the Eastern laboratory staff interested the University of Pennsylvania in making clinical tests. The essential clues which led Dr. Couch to suggest the medical research was the marked similarity of the chemical structure of rutin to "Vitamin P" and the findings of A. Szent-Györgyi, Hungarian bio-chemist, who first isolated Vitamin C nearly 15 years ago.

The clinical research was conducted by Dr. J. Q. Griffith, Jr., of the University of Pennsylvania, who has prepared an official report of the improvements that have resulted from the use of rutin.

The Eastern laboratory prepared about 20 pounds of rutin of medicinal purity from freshly harvested buckwheat plants. That was more rutin than had ever been isolated before, and samples adequate for evaluation were supplied to more than a hundred physicians and pharmacologists for use in clinical studies in 1945. The results gave further evidence of the value of rutin for reducing increased capillary fragility and showed that thiocyanates and other drugs for reducing high blood pressure can be used safely after treating with rutin.

Rutin research, which has resulted in the discovery of new uses for a long known substance, stemmed from earlier investigations of industrial uses of tobacco. When the flue-cured leaves yielded appreciable quantities of rutin, the research was directed toward the value of the drug. The co-operation of the Pennsylvania medical school as well as the USDA's Bureau of Animal Industry was necessary to bring the research to the commercial and medical conclusion it has reached at this time. At least four pharmaceutical houses are planning commercial production in 1946 as a result of small scale experimental manufacture last year in cooperation with the Eastern laboratory staff.

## Health In 1799

Dr. R. Squirrell gives the following advice in the third edition of his little book entitled, *Making of Health, Being An Abridgment of An Essay on Indigestion, including also a Treatise on Sea and Cold Bathing*. London, 1799:

*Bathing.* The best time of year for bathing, in general, is to commence about the middle of April, or beginning of May, according to the temperature of the season, and to continue it no longer than a month, or six weeks at a time; and it should never be employed later in the season than the beginning of November.

*Swinging* is productive of great benefit to the constitution.

*Study.* Excess of study is so powerful a cause of indigestion, nervous diseases, hypochondriasis, and the gout, that I find very few men of learning are free from these complaints. Intense thinking wears out the constitution more than the most laborious exercise.

For the cure of all sorts and conditions of trouble, Dr. Squirrell recommends the use of his *tonic powders, in packets, and tonic drops, in bottles*.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

Funeral services for Mrs. Alfred Labensky, president-elect of the Woman's Auxiliary to the State Medical Society, were held in St. James Episcopal Church, New London, Friday afternoon, January 3, at 2:30 o'clock.

Officers of the Auxiliary who attended the services included Mrs. James D. Gold, president; Mrs. Creighton Barker, Mrs. Edwin Connors, and Mrs. Frank DiStasio. Burial was in Cedar Grove Cemetery, New London.

Ardently devoted to affairs of the Auxiliary, Mrs. Labensky was one of its earliest organizers. Organization chairman of the New London County Auxiliary during its inception, she later became its president, and in 1946 was elected to the office of president-elect of the State Auxiliary.

## THE DOCTOR'S OFFICE

Hoyt C. Taylor, M.D., announces the removal of his office to 199 West Main Street, Meriden, January, 1947, for the practice of gynecology and obstetrics.

Michael C. Anton, M.D., of New Haven, former resident physician at the Bridgeport Dispensary and emergency hospital, who interned in St. Vincent's hospital, will open his offices in the former quarters of the late Dr. E. H. J. Hennessey shortly after January 1. A veteran of World War II, Dr. Anton is at present finishing a post graduate course in Chicago.

Carl E. Johnson, M.D., Jachin B. Davis, M.D., William R. Richards, M.D., announce the removal of their offices for the practice of obstetrics and gynecology to 364 Oak Street, New Haven.

Andrew Taylor, M.D., having recently returned from military service, announces the opening of his offices at 179 Allyn Street, Hartford. Practice limited to proctology.

Thomas F. Murphy, M.D., announces the reopening of his office at 683 Asylum Avenue, Hartford. Practice limited to pediatrics.

## OUR NEIGHBORS

### Nursing at Rhode Island Hospital

In an effort to aid in improving nursing service at Rhode Island Hospital the Board of Trustees at a regular meeting on November 6, 1946, voted:

1. That the Board of Trustees go on record as favoring legislation to license in Rhode Island vocational, practical or attendant nurses and that the necessary steps to aid in the preparation and passage of such legislation be taken.

2. That the Board of Trustees approve a plan for the development of a corps of paid nurses aides, such a corps to be developed by recruitment of suitable women and giving them a training course of 6 weeks' duration. (Former Red Cross volunteer nurses aides or other women with similar training if employed will not be required to take the course.)



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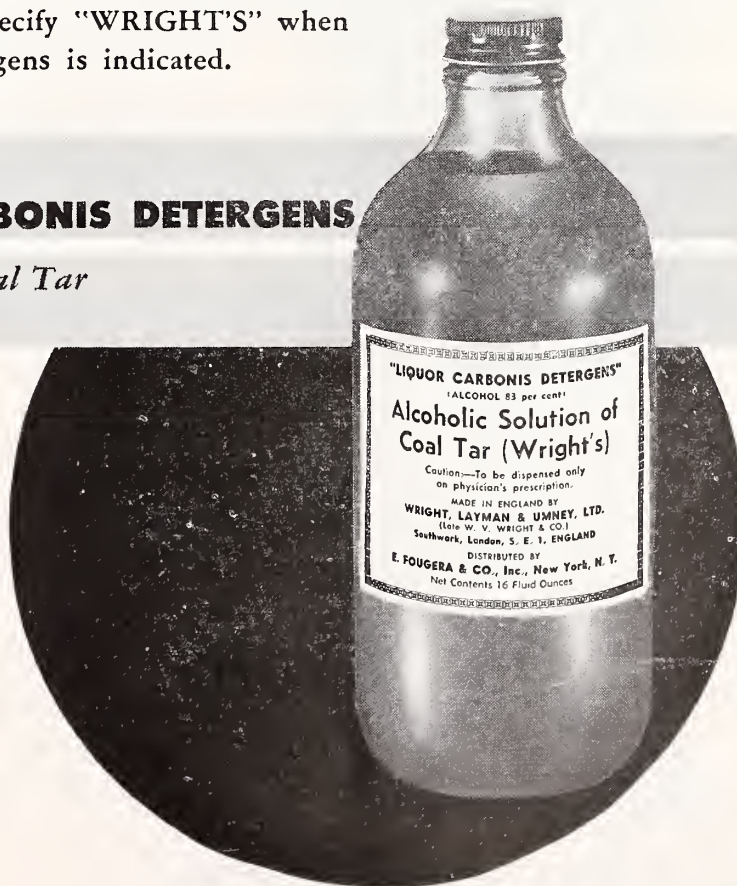
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The pay schedule for this group is to be in proper relation to other vocations or skills and to include compensation during the training period.

3. That the Rhode Island Hospital continue to deal with nurses as a professional group. On this basis the Rhode Island Hospital will have a schedule for staff or general duty nurses with one day off one week and a day and one half the alternate week and with a total cash salary scale beginning at the generally accepted level of \$170 per month and increasing on the basis of merit to a maximum of \$200 a month. This is to be effective December 1, 1946.

4. That the Board of Trustees officially support a recruitment drive and approve the principle of financial aid or scholarships as a tool for increasing the number of nurses and improving the quality of nursing service.

5. That the Committee on Nursing of the Board of Trustees be authorized to represent the Board in discussion of these points and any others of a pertinent nature with representatives of the Boards of other hospitals and others interested in and with responsibility for the Public Health.

6. That the Board of Trustees appreciating the value of collaboration among the hospitals of Rhode Island authorize and instruct the administration to send copies of a statement relative to nursing embodying the votes of the Board to:

(a) All hospitals in Rhode Island

(b) The officers of—

1. The Rhode Island Medical Society.

2. Rhode Island State Nurses Association.

3. The Hospital Association of Rhode Island.

(c) and later to the press.

The Medical Staff Executive Committee of the hospital has approved the first four principles.

### New Jersey

To its other accomplishments New Jersey has now added the establishment of a full partnership group in Newark. The new Newark Clinical Group will pool all income from patients and thereby come even closer to the Medical Group Practice Council's definition which is "an association of physicians of different skills, using medical equipment and administrative personnel in common, with a formal pattern

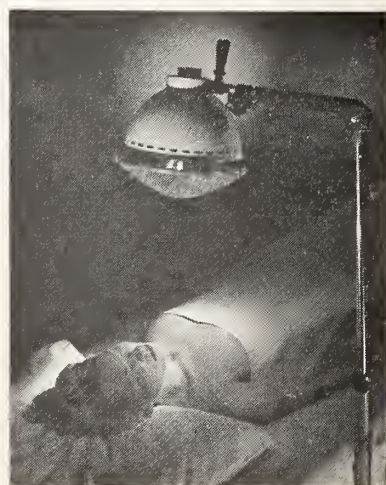


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Moderately priced, the Burdick Prescription Ultraviolet lamp has the same quality radiation as the largest Burdick Ultraviolet lamp, the "Professional Special," with less intensity and is widely used by physicians who have moderate use for Ultraviolet therapy. Telescoping stand and patented adjustable arm allow full coverage radiation in any position.

### Healing Heat . . . .

The Burdick ZOALITE provides maximum latitude of adjustment, convenience and ease in operation. Model Z-12, illustrated, is equipped with a 600 watt Burdick patented single bar non-metallic element and double wall ventilated reflector. Stand has new double-duty adjustable arm and low gravity base.



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of professional collaboration, and a unified administrative and financial organization.”

It is expected that 1947 will see the birth of many new medical groups in the east—the one area in the country where this type of organization has flourished least. Nonparticipants will view this trend with attitudes varying from tongue-in-cheek curiosity to outspoken hostility.

NEWS

from County Associations

Hartford

The New Britain Medical Society held two meetings in November and December. At the first of these Margaret A. Lennox, assistant professor of neurology at Yale University School of Medicine, spoke on “Clinical Applications of Electroencephalography.” Howard F. Root, instructor in medicine at Harvard Medical School, addressed the second meeting on “Surgical Complications of Diabetes Mellitus.”

The guest editorial entitled “A Program for a Continuing Postgraduate Medical Education” published in *Virginia Monthly*, October 1946, was written specially for that publication by James Raglan Miller, president-elect of the Connecticut State Medical Society.

At the annual meeting of the Hartford Medical Society the following officers and committeemen were elected for 1947: C. Charles Burlingame, president; Benedict B. Landry, president-elect; Sidney S. Quarrier, secretary; Rocco J. Romaniello, assistant secretary; David Gaberman, treasurer; Maurice T. Root, assistant treasurer; Edward J. Whalen, librarian; Louis P. Hastings and Louis F. Middlebrook, associate librarians; Orin R. Witter, Otto G. Wiedman, and Thomas H. Denne, trustees; Morris M. Mancoll, member of house committee.

Middlesex

Our Board Room is bubbling over with ideas since the return of Drs. LaBella, Vinci and Sweet from the American College of Surgeons meeting in Cleveland. In addition to knowledge Dr. LaBella returned with sore feet from pounding the pavements.



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Whether it's for luncheon, dinner or supper, there's nothing more appealing to convalescent appetites than a rich, flavorful cup of Maggi's Bouillon.

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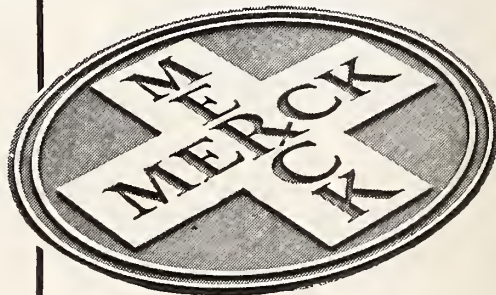


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Dr. Vinci was inducted into membership in the College of Surgeons during this conclave. Our members are making their mark professionally.

We are watching with considerable interest the reports emanating from the lower County towns in respect to the proposed 100 bed hospital being organized to supply the needs of the "Down County" towns.

At the December meeting of the Central Medical Association Dr. Benjamin Simon displayed the documentary film "Let There Be Light" a marvelous record of the work done by the neuropsychiatric divisions of the Army. Dr. Simon, one of our members, was the chief of Service at one of the largest of these centers. Both the members and many of their wives were fascinated by the methods and amazed at the results obtained.

A daughter, their second child, was born at the Middlesex Hospital to Dr. and Mrs. Vincent J. Vinci.

Some of our members can not be accused of being

unintellectual. Every Saturday now sees Dr. Magnano trekking to the Metropolitan Opera. He and Dr. LaBella are listed as subscribers to a Box at the Opera. Several of us less fortunate ones are also benefiting by their interest in this "Extravaganza."

We welcome Dr. Harold Smith to our professional family. Becoming tired of the hustle and bustle of the New York City life he is now enjoying the advantage of a "quiet" country practice.

### New Haven

The annual Christmas party of the New Haven Society was a huge success with practically every member of the Society, both from New Haven and the outlying towns, present.

Members of the New Haven County Medical Association will be the guests of the Waterbury Medical Association at a meeting to be held at the Castle Memorial on the evening of February 13. Notices are being sent to the County Association members.

## ORTHOPEDIC SURGERY IN CONNECTICUT

THE JOURNAL OF THE CONNECTICUT STATE MEDICAL SOCIETY

*announces with pleasure*

*the publication of a limited edition in book form of the*

## HISTORY OF ORTHOPEDIC SURGERY IN CONNECTICUT

*written by DR. PAUL SWETT of Hartford*

Those who are familiar with this important and fascinating chapter in our medical history will welcome this opportunity to add this significant volume to the doctor's library. The price is two dollars. Copies may be secured from Connecticut State Medical Society, 258 Church Street, New Haven, Conn.



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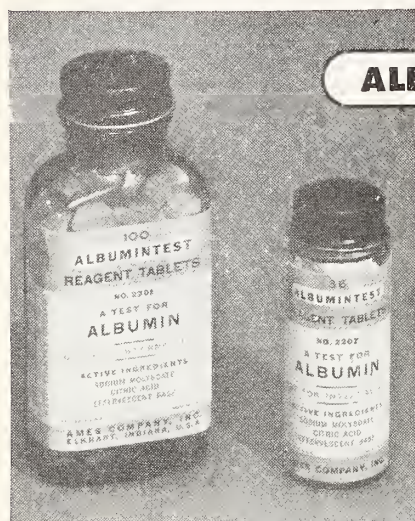


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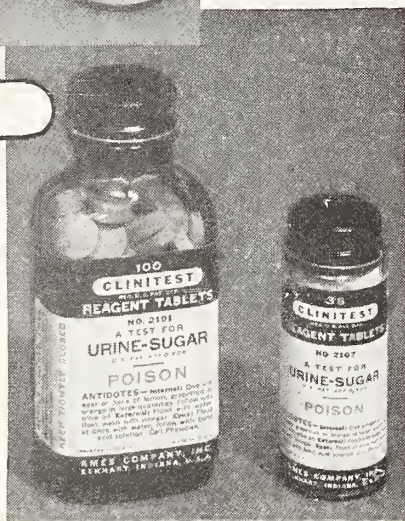


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## New London

Dr. Herman O. Schmidt joined the staff of the Norwich State Hospital on September 1, 1946, as director of Psychological Laboratories. Dr. Schmidt received his early education in Baltimore, Maryland, graduating from Baltimore City College in 1922. He received his A.B. degree at Johns Hopkins University in 1926 and his PH.D. at Johns Hopkins in 1940.

During the World War II he served in the United States Army as Lieutenant Colonel. Following his discharge from the Armed Forces and prior to his appointment to the Norwich State Hospital he was clinical psychologist at the Neurosis Center, Veterans Administration, Batavia, New York.

Surgeon Wingo, M.D., graduate of Louisiana State University, joined the surgical staff, Uncas-on-Thames, in December 1946. He saw service in the Armed Forces as senior assistant surgeon, USPHS.

The New London County Society will meet at the Norwich State Hospital for their February meeting. Dr. Guthrie and his staff will present an interesting program.

## News from Yale University School of Medicine

The W. H. Carmalt Lecture on the History of Medicine, sponsored by the Beaumont Medical Club, will be given by Dr. E. B. Krumbhaar of Philadelphia on Friday, February 7, at 4:30 P. M., in the Historical Library of the School of Medicine. Dr. Krumbhaar's subject will be "The State of Pathology in the British Colonies of the Atlantic Coast in the Seventeenth and Eighteenth Centuries." Members of the Connecticut State Medical Society are invited to attend.

### SCHEDULE OF PHARMACOLOGICAL SEMINARS FOR FEBRUARY 1947

February 6

To be announced later

February 13

Dr. Oscar Bodansky, department of pharmacology, Cornell University Medical College  
"Physiological and Clinical Aspects of Methemoglobinemia"



February 20

Dr. Ralph W. Brauer, department of pharmacology, Harvard Medical School

"Factors Affecting the Plasma Esterase Level in the Dog and in the Rat"

February 27

Dr. Arthur J. Geiger, department of medicine, Yale University School of Medicine

"Treatment of Subacute Bacterial Endocarditis with Penicillin"

4:10 P. M., Room B203, Sterling Hall of Medicine

John S. Lockwood, formerly associate professor of surgery at Yale, has been appointed professor of surgery at Columbia University College of Physicians and Surgeons. Dr. Lockwood will also serve as attending physician at the Presbyterian Hospital.

## NEW BOOKS IN REVIEW

**PRACTICAL MALARIOLOGY:** Prepared under the Auspices of the Divn. of Medical Sciences of the National Research Council. *Paul F. Russell*, M.D., M.P.H., Colonel, M.C., A.U.S., Parasitology Divn., Army Med. Sch., Field Staff, Internl. Health Divn., Rockefeller Foundation (on leave); *Luther S. West*, PH.D., Head of Biology Dept., Northern Michigan College of Education, Major, Sn.C., A.U.S. (Reserve); Formerly Entomologist, Parasitology Division, Army Medical School; *Reginald D. Maxwell*, sc.D., Professor of Zoology, Syracuse University, New York, Formerly Captain, Sn.C., A.U.S., Protozoology Section, Parasitology Division, Army Medical School. Foreword by *Raymond B. Fosdick*, President of The Rockefeller Foundation. 684 pp., 238 illustrations, 8 in color. Philadelphia & London: W. B. Saunders Company. 1946. Price \$8.00.

Reviewed by WILMOT C. TOWNSEND

*Practical Malariology* is a complete volume about malaria and its many ramifications. The senior author has been identified with malaria for years as field director of the Rockefeller Foundation and during the war he was chief malarialogist in the Mediterranean Theater.

The vast literature on malaria, including the most recent advances, has been assembled in a well balanced and integrated pattern. A historical introduction is followed by six sections, describing in detail the parasite, the mosquito, the man, the community, prophylaxis and therapeutic malaria. An appendix lists the keys to the world anophelines. Numerous illustrations, colored plates and photographs add greatly to the text.

This volume is complete, authoritative and up to date. The malarialogist, teacher and student will find it invaluable. Most of the material will not interest the practicing physician, but pertinent information is easily obtained such

as staining of blood films and identification of the parasite, and the symptomatology, pathology and treatment of the disease.

**VICTORY OVER PAIN—A HISTORY OF ANESTHESIA.** By *Victor Robinson*, M.D. New York: Henry Schuman. 1946. 338 pp. with illustrations. \$3.50

Reviewed by GEORGE A. DELMONTE and RALPH M. TOVELL

It is very appropriate and opportune for the history of anesthesia to be retold at this time because one hundred years ago Morton gave the first public demonstration of the anesthetic properties of ether at the Massachusetts General Hospital in Boston. Dr. Robinson, who was an outstanding authority on medical history, describes this, "Victory Over Pain," in a very interesting and fair manner. He has probed the lives of the men about whom he writes and has made his narrative most convincing and enjoyable.

The book begins with the earliest recorded use of drugs in the mitigation of pain. The author's description of such reputed analgesics as mandrake root, hellebore, dittany and mulberry are interesting. The death of Socrates as depicted by Plato is graphically retold. From the outline of these early attempts at control of pain, he follows with the description of methods used in the Middle Ages, the Renaissance, and through the seventeenth and eighteenth centuries. To set the stage for the great discovery the work of such men as Humphrey Davy, Hickman and Mesmer is described. It is pointed out, for example, that Davy knew of the anesthetic properties of nitrous oxide and, though he published his results, the facts were not sufficiently emphasized to register in the minds of his contemporaries.

The discovery of anesthesia is then told by a chronological account of the lives and contributions of Long, Wells, Jackson and Morton. Long was the first to use ether for anesthesia in 1842, but he did not appreciate its importance and gave it little or no publicity. Wells appreciated the anesthetic properties of nitrous oxide and realized its possibilities but his attempts to publicize his discovery met with unfortunate and ill-timed failure. Jackson suggested the use of ether to Morton, the opportunist, who used it successfully and demonstrated it well. The controversy is objectively described and the reader is impressed with the author's fairness in his analysis of the controversy.

The story of the reception of the discovery in Europe and the discovery of chloroform by Simpson makes fascinating reading. The introduction of local and spinal anesthesia as well as the development of intravenous anesthesia and the endotracheal technique is recorded accurately and proper emphasis is placed on those contributions which have paved the way of modern anesthesia.

Dr. Robinson has compiled this interesting history in an appealing manner. He has made it a personal account of the men concerned. Physicians will appreciate its details. Those outside the profession will enjoy the series of well knit, related, short stories which comprise the history of anesthesia up to the present day. The dedication to Drs. A. E. Guedel and R. M. Waters seems particularly apt. It is little wonder that the eminent scholar Jacobi was prompted to tell the men at Yale: "The greatest gift America has given the world is not the realization of a Republican Govern-

ment—It is Anesthesia.” This book is recommended for enjoyable and instructive reading. Dr. Robinson’s efforts will be conducive to an appreciation of anesthesia and the service of anesthetists by the public.

**PSYCHOANALYZE YOURSELF — A PRACTICAL METHOD OF SELF-TREATMENT.** By E. Pickworth Farrow, M.A., D.Sc., with foreword by the late Professor Sigmund Freud, M.D., LL.D., FORMEM.R.S. New York: Interantional Universities Press. 1945. 157 pp. \$2.00.

Reviewed by MAUDIE MARIE BURNS

While this book undoubtedly contains much material that is of value, it is mainly so from an historical point of view. The author is to be commended for his painstaking effort to show what it was possible for him to accomplish alone in further understanding himself after his work with two different analysts. However, recommending the technique for others who have not had his training and experience holds out a false hope. It is undoubtedly true that the average person gains by being honest and frank with himself about reality but to encourage the use of as highly specialized a technique as psychoanalysis by the average person is considered dangerous. If for no other reason, the authors statement in the preface that the book represents 2,800 hours of research spread over 18 years would render such a technique as his impractical, as the average person sick enough to need psychoanalysis doesn’t want to spend 18 years getting well.

The choice of the title used is unfortunate as it serves to emphasize and point up the above mentioned impractical and unhealthy idea and detracts from the real value of the book from the historical point of view.

## NEW NATIONAL FORMULARY VIII AVAILABLE DECEMBER 15, 1946

The Council of the American Pharmaceutical Association is pleased to announce that the new, completely revised and enlarged National Formulary will be generally available on and after December 15, 1946. This edition, the eighth published by the American Pharmaceutical Association since 1888, provides official specifications for many widely used drugs not previously included in either the U. S. Pharmacopoeia or the National Formulary. Copies of the new edition may be obtained from the Mack Publishing Company, 20th and Northampton Streets, Easton, Pennsylvania, at \$7.50 per copy.

Among 188 new admissions to the revised N. F. VIII are such drugs and preparations as Acetarsona, Alcohol Rubbing Compound, Aminoacetic Acid Elixir, Calcium Levulinate, Colloidal Silver Iodide, Ephedrine Sulfate and Phenobarbital Capsules, Ferrous Sulfate Syrup, Isopropyl Alcohol Rubbing Compound, Gentian Violet Jelly, Pentobarbital Elixir, Propylene Glycol, Sippy Powders, Stibophen, and a sun protective ointment.

In addition, formulas and standards are continued in the

new National Formulary for many U. S. P. XII drugs not admitted to U. S. P. XIII of which Antipyrine, Bismuth Subnitrate, Camphor Spirit, Ergot and Ergot preparations, Ferrous Carbonate Pills, Reduced Iron, Mercury Bichloride, Nux Vomica, Phenyl Salicylate, and Turpentine Oil are a few examples.

The arrangement of monographs in the National Formulary differs from that of previous editions in that Latin titles, although continued, are preceded by English titles. Monographs are arranged in alphabetic sequence, but in a different order than heretofore. For example, Terpin Hydrate is followed by Terpin Hydrate and Codeine Elixir, and Terpin Hydrate Elixir, and Acetarsona Tablets follow Acetarsona in the new arrangement.

To facilitate the use of the new arrangement, a marginal index is included throughout the book. This is only one of several innovations in the new National Formulary.

The Eighth Edition of the National Formulary represents the culmination of four years of planning and work by the members of the Committee on National Formulary, the staff of the American Pharmaceutical Association Laboratory, and hundreds of collaborators connected with college, governmental, institutional and industrial laboratories.

The actual revision work has been carried on in the Laboratory and offices of the American Pharmaceutical Association located in its own building at Washington, D. C.

The needs of the practicing pharmacists as well as the use of the book as a legal standard have been kept in mind constantly in the preparation of the new Eighth Edition of the National Formulary, since this book is one of the official compendia recognized as a source of drug standards in Federal and State food and drug laws.

The Committee of Revision, under the Chairmanship of Dr. Justin L. Powers, has conducted its work by correspondence, through the National Formulary Bulletin, and by occasional meetings of the full Committee and various subcommittees.

The National Formulary is now on a continuous revision basis, so that the publication of N. F. VIII is incidental to the continuous research and development of effective standards for drugs based upon demonstrated therapeutic value or extensive use. As new standards or formulas are devised they will be made known through interim revisions or supplements to the N. F., obtainable from the American Pharmaceutical Association office.

The new N. F. VIII becomes official April 1, 1947, and it will be necessary for practicing pharmacists and others to have the book on hand prior to that date to meet the requirements of the various State pharmacy and food and drug acts.

Because of the general industrial situation with respect to printing, paper supplies and binding materials, the first printing has been limited to some extent. It is therefore urged that pharmacists avoid any delay in securing their copies of the N. F. VIII by ordering immediately.

Robert P. Fischelis, Secretary



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## *Trauma and Nitrogen Equilibrium*

Recent recognition of the direct relationship between trauma and protein loss has greatly improved the prognosis in postsurgical and post-trauma patients.

Striking and hitherto unsuspected protein loss has been observed in patients with fractures. Excessive urinary nitrogen excretion reaches its maximal point about a week after the injury is sustained, and thereafter slowly diminishes in extent, so that nitrogen balance is restored in approximately four weeks.<sup>1</sup>

In patients sustaining severe burns, the daily protein loss may be equivalent to 400 cc. of plasma.<sup>2</sup>

In a study embracing 23 burned patients, nitrogen balance determinations revealed excessive urinary nitrogen excretion. Nearly all patients were in negative nitrogen balance which was most marked during the first ten days.<sup>3</sup>

It thus appears that protein destruction and loss are prominent and potentially detrimental sequelae of trauma, and that every effort must be made to restore nitrogen equilibrium as quickly as possible to prevent the many deleterious consequences of protein depletion. The recommendation has been voiced that "whenever possible, protein losses or deficiencies should be corrected by oral feeding."<sup>4</sup>

Among the protein foods of man, meat ranks high not only because of the generous supply of protein it provides, but also because its protein supplies all the essential amino acids, making it applicable for every protein need—growth, tissue maintenance, and tissue repair.

<sup>1</sup> Howard, J. E.: Bull. Johns Hopkins Hosp., 74:313 (May) 1944.

<sup>2</sup> Co Tui, C.; Wright, A. M.; Mulholland, J. H.; Barcham, T., and Breed, E. S.: Ann. Surg. 119:815-823 (June) 1944.

<sup>3</sup> Hirshfeld, J. W.; Abbott, W. E.; Pilling, M. A.; Heller, C. G.; Meyer, F.; Williams, H. H.; Richards, A. J., and Obi, R.: Arch. Surg. 50:194 (Apr.) 1945.

<sup>4</sup> Lund, Chas. C., and Levenson, S. M.: J. A. M. A. 128:95 (May 12) 1945.

The Seal of Acceptance denotes that the nutritional statements made in this advertisement are acceptable to the Council on Foods and Nutrition of the American Medical Association.



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# *The* CONNECTICUT STATE MEDICAL JOURNAL

VOL. XI

MARCH, 1947

No. 3

## DIAGNOSIS OF PERIPHERAL ARTERIAL DISEASES

HUGH MONTGOMERY, M.D., *Philadelphia*

The Author. *Associate in Medicine, University of Pennsylvania Medical School, Chief of the Peripheral Vascular Section, Hospital of the University of Pennsylvania*

THIS PAPER is a plea for early and accurate diagnosis of peripheral arterial diseases. A generation ago so little was known of the life history of peripheral vascular diseases that little could be done to ameliorate the suffering resulting from them. During the past generation, however, much useful therapeutic and prophylactic information has accumulated. We now know that a collateral arterial circulation can be an adequate substitute for the original circulation damaged by occlusive processes. We also know that it is very important to avoid injury and infection of ischemic tissue. Early recognition of arterial disease affords a physician the opportunity to prevent, or at least to defer, the dangerous consequences of diseased arteries. A generation ago occlusive peripheral arterial disease was diagnosed when gangrene appeared. Today it is possible to diagnose much earlier, and usually to prevent gangrene.

### DEFINITION OF "DIAGNOSIS"

Diagnosis can be defined as the classification of type of disease. Thorough diagnosis, however, classifies with a name, and then points out the degree of physiological impairment. In the present paper I wish to use the term diagnosis in these two senses, classifying and then estimating the type and degree of physiological impairment. Then diagnosis and therapy of the patient are reasonably understandable.

### ISCHEMIA

Most of the diseases we are concerned with here cause symptoms because of the ischemia produced by the diseases. Moderate ischemia produces blanching and coldness of the skin of the affected part. Severe ischemia causes blanching, coldness, cyanosis, paresthesias, pain, intermittent claudication, atrophic changes in skin and nails, indolent ulceration, and even gangrene. Vasospastic diseases cause ischemia, but the ischemia is reversible when the patient is thoroughly warmed, and so is usually insufficiently prolonged to cause ulceration and gangrene. Organic, occlusive, arterial disease causes ischemia which is irreversible. Thorough warming of the body still results in only restricted vasodilation in the affected part until such time as a full collateral circulation becomes established.

In using the symptoms and signs of ischemia diagnostically it is important to remember that transient ischemia is a physiological process in normal people. It occurs on exposure to cold or under emotional strain, and on sufficient exposure to severe stimuli may be as intense as the ischemia in vasospastic or in organic occlusive arterial disease. Physiological ischemia, is however, readily distinguished from pathological degrees by its being very readily reversible.

Organic occlusive arterial disease is readily recognizable when pulses are absent or when chronic ulceration or gangrene is present. In the absence of these factors it can be recognized because it produces ischemia that is unequal in intensity bilaterally. This inequality of ischemia in two feet can be demonstrated most strikingly by heating the body

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of the patient with heating pads, and observing the inequality in temperature of the two feet. Full vasodilatation cannot be produced in the affected parts. The more complete the occlusion, the less the vasodilatation. Estimations of the resultant blood flow made by measurements of skin temperature of the feet, will, under standard conditions, reveal even minor grades of occlusive vascular disease. It is in part for this reason that the so called vasodilatation tests have come into prominence in recent years in the early diagnosis of arterial diseases. Their main usefulness, however, is in estimating the degree of arterial occlusion that is not relieved by a collateral circulation.

Somewhat similar tests have recently been devised to estimate the degree of peripheral vasomotor tone in various patients. The amount of heat that must be applied to the body to produce full vasodilatation is in proportion to the degree of vasomotor tone. Or conversely, the rate of development of peripheral vasoconstriction, when the patient is in a cool room is a measure of the peripheral vascular tone. Patients can be graded as having one or another degree of vasomotor tone characteristic of the individual. This is beginning to have some diagnostic significance, but so far is more useful in testing the function of the peripheral vessels than in making diagnoses.

#### LIST OF DISEASES

I will read a list of the diseases with which we are concerned, and then take up the salient clinical diagnostic points of each disease. The conventional classification of these diseases of the peripheral arteries falls naturally into two groups, the primarily vasomotor group and the primarily organic group. The vasomotor group comprises several diseases in which there is abnormal vasoconstriction: acrocyanosis, Raynaud's disease, the secondary Raynaud phenomena as occur in scalenus anticus syndrome and causalgia, and also the one disease in which there is an abnormal degree of vasodilation, namely erythromelalgia. The organic diseases of the peripheral arteries are the most important ones. The occlusive organic diseases are: arteriosclerosis, thromboangiitis obliterans (i.e. Buerger's disease), peripheral arterial embolism, frost bite, immersion foot, trench foot, coarctation of the aorta, periarteritis nodosa, and ergotism. The hyperemic organic arterial diseases are angiomas, arterio-venous fistulae, and glomangiomas.

#### DIAGNOSIS OF DISEASES

Now to go back through this list of diseases to review the salient clinical diagnostic points of each, starting with the vasomotor group. (1) Acrocyanosis exhibits itself clinically as mottled beefy-red hands. Acrocyanosis is aggravated by exposure to cold. After exposure to cold the hands take on a cyanotic tinge. Arteriolar spasm with dilatation of capillaries and venules cause the redness and cyanosis. The disease is bothersome for cosmetic reasons. Histamine 1/1000 needled into the skin causes a wheal and flare because of its effect on the spastic arterioles. This test serves to help differentiate it from Raynaud's disease.

(2) Raynaud's disease manifests itself clinically by cyclic phases of extreme vasospasm, of equal degree on each side of the body, in fingers and to a lesser degree in the feet. On exposure to cold or during excitement, the smaller fingers of each hand blanch, tingle, and become numb, and if the attack is allowed to last long the fingers become painful. On warming, the hands become cyanotic, deep red, and then normal in color. Extreme degrees of Raynaud's disease may cause pitting of fingertips or even symmetrical gangrene of the extreme tips of the fingers. The ischemic manifestations come from spasm of small arteries rather than from spasm of arterioles. In contradistinction to acrocyanosis, the spasm of Raynaud's disease fails to give way to histamine needled into the skin because the histamine does not reach the arteries. Raynaud's disease is much more frequently seen in women than in men. This sex relationship must be kept in mind in making the diagnosis, so much so that one dare not make the diagnosis of Raynaud's disease in a man until the patient has been observed over a long period, so that incipient thromboangiitis obliterans and its secondary Raynaud's phenomena can be ruled out. Exceptions to this statement are male patients who use vibrating tools. Pneumatic hammers frequently cause, temporarily, a disease indistinguishable from Raynaud's disease.

(3) Secondary Raynaud phenomena are spastic, cyclic phenomena resembling those of Raynaud's disease but occurring in other diseases. They are common in thromboangiitis obliterans, frost bite, rheumatoid arthritis, scleroderma, acute thrombophlebitis and scalenus anticus syndrome, and may occur in occlusive peripheral arteriosclerosis. Their detection results from recognition of the primary



disease. Usually Raynaud's phenomena secondary to organic disease are distributed asymmetrically, one hand or foot being more affected than the other. If one or more pulses are absent the Raynaud phenomena are known to be secondary to occlusive arterial disease. Unfortunately the converse is not necessarily true—the presence of all pulses in extremities exhibiting Raynaud phenomena does not prove Raynaud's disease, for all pulses are present in frost bite, rheumatoid arthritis, and scleroderma, are usually present in scalenus anticus syndrome, and may be present in early thromboangiitis obliterans. Consideration of diagnosis of these conditions will be given a little later.

(4) Scalenus anticus syndrome usually manifests itself by intermittent paresthesias of a hand and arm, accompanied by secondary Raynaud phenomena in the hand. Secondary thrombosis may occur. It differs from Raynaud's disease in being of unequal intensity in the two hands. There is usually tenderness over the scalenus anticus muscle on the affected side. Changing the position of the arm is less likely to obliterate the pulse at the wrist than most of the literature on the subject claims. Cervical rib sometimes produces scalenus anticus syndrome.

(5) Causalgia is probably best classified with the secondary Raynaud phenomena. Traumatized tissue usually heals satisfactorily, but in some instances, under conditions that are not understood, the healing process is accompanied by vasospasm and pain that may persist for months. This is especially true of injury to bone, more especially to injuries of the bones of the feet and hands. The pain appears to be vasospastic in origin, because relief of arterial tone, by interruption of vasomotor nerve impulses, will relieve the pain. Indirect evidence of the vasospastic origin of causalgia is the diffuse demineralization of bone in longstanding causalgia, usually referred to as Sudek's atrophy. This demineralization is sometimes found in ischemic extremities in other arterial diseases.\*

(6) Erythromelalgia or erythralgia exhibits itself to a patient as burning and prickling of the hands, or more commonly of the feet. The pain may be severe. The foot, or hand, is excessively warm to the touch. The arterioles and capillaries are widely dilated. The condition is rare as a primary disease, but mild grades of it are not uncommon in feet made ischemic by occlusive arteriosclerosis in which a collateral circulation has grown.

(7) Peripheral arteriosclerosis is by far the commonest of the severe peripheral arterial diseases. It occurs both in men and in women, but somewhat more frequently in men. It is a disease of late middle age and old age, but occurs earlier in patients with diabetes. The so called degenerative changes of the arteries pave the way for thrombotic occlusion and resultant ischemia. Collateral blood supply may for years prevent serious degrees of ischemia, and then only when a toe is traumatized by some mechanical, thermal, or bacterial agent, will the disease manifest itself to the patient. This series of events is unfortunate. Early recognition by a physician, and prophylactic measures, will in most instances avoid serious sequelae. The present paper is primarily a plea for the early recognition of peripheral arteriosclerosis obliterans, preferably before any symptoms occur. Routine physical examinations will detect the absence of one or more pulse in an ankle, and will establish the fact that there is occlusion of peripheral arteries. Only about 2 per cent of pulses are absent by reason of anomaly. X-ray of the foot and leg will confirm the diagnosis of arteriosclerosis if it shows calcification of peripheral vessels, but if no calcium is seen it by no means excludes the diagnosis. Absence of a pulse in a diabetic is almost pathognomic of peripheral arteriosclerosis with occlusion. The age of the patient, the absence of causes for peripheral arterial emboli, the absence of a history of severe local trauma to explain the absent pulse, and exclusion of thromboangiitis obliterans, all are factors which taken together make the diagnosis of peripheral arteriosclerosis with occlusion. Biopsy is contraindicated because of the poor healing of ischemic tissue and possible further damage to the circulation. Symptoms of ischemia, and tests to demonstrate degrees of ischemia are important in judging the degree of damage and the extent to which a collateral circulation has taken over, but are not in themselves strictly speaking diagnostic procedures.

(8) Thromboangiitis obliterans (i.e. Buerger's Disease) is characterized by inflammation of arteries and veins. This inflammation paves the way for thrombosis and scarring of the vessels. The consequence is occlusive vascular disease. The resultant ischemia is distributed much as in arteriosclerosis. The salient diagnostic features are (a) the relatively young age of the patient (b) the rarity of the disease in women, and (c) the history or physical finding

of the so-called migratory phlebitis that characterizes the disease when the phlebitis is recognizable. Migratory phlebitis, unlike usual forms of phlebitis, manifests itself as small, tender, reddened, areas in proximity to the superficial veins of the feet, ankles, hands and wrists. These red areas last a few days and change to non tender brownish areas lasting two or three weeks. A carefully taken history will uncover migratory phlebitis in about a third of the patients having the disease. Clinical evidences of the acute arteritis are much less commonly detectable. The difficulty in diagnosis of thromboangiitis obliterans that lacks these evidences of inflammation comes in the middle age group, halfway between that of this disease and of arteriosclerosis. Roentgen examination of the extremities swings the diagnosis to arteriosclerosis when calcium is detectable in the arteries, but the absence of calcium is not diagnostic. The presence of diabetes weights the diagnosis heavily in favor of arteriosclerosis. Biopsy of a vein is usually diagnostic of thromboangiitis obliterans, but is rarely resorted to because therapy of the middle-aged patients with thromboangiitis obliterans is much the same as that for arteriosclerosis.

(9) Peripheral arterial embolism is readily diagnosed if rheumatic valvular heart disease or recent coronary occlusion are demonstrable. These two cardiac diseases are by all means the usual causes of peripheral arterial embolism sufficient to damage the peripheral arterial circulation significantly. The thrombi in the left heart in rheumatic valvular disease are most likely to form when the auricles are fibrillating, but fibrillation is not a necessary precursor. Examination of the heart and sometimes electrocardiography are required in diagnosing peripheral arterial embolism. The thrombus of the left ventricle resulting from coronary occlusion is most likely to fragment and produce emboli within the first two weeks, but may do so even years after the coronary occlusion. Significant peripheral arterial embolism usually produces sufficiently sudden and severe ischemia to give a hint that the source is embolic. Not infrequently the source of the embolus is detected only after the embolus has lodged. Other causes of significant peripheral arterial embolism, including atheromatous plaques from the aorta, are rare. Peripheral emboli from the verrucous vegetations on heart valves caused by subacute bacterial endocarditis are rarely of sufficient size to jeopardize the peripheral circulation in the way they cause infarcts in central organs. Oil em-

bolus is a rare but distressing result of the common practice of intramuscular injection of drugs in oil.

(10) Frostbite, immersion foot and trench foot are somewhat similar in that direct chilling plays a part in each, and the damage that results involves blood vessels and nerves, as well as other tissues. Immersion foot and trench foot are practically identical pathological entities. Frostbite results from exposure to freezing temperature, whereas both immersion foot and trench foot result from prolonged exposure to cool water or moisture but not to freezing. The essential lesion in frostbite is local necrosis of all tissues in response to the formation of ice crystals in the tissues. The vessels and nerves are involved only in that locality. In immersion foot and trench foot, but not in frostbite, the nerves degenerate far more widely than in the area of necrosis. Another differentiating point is that necrosis is deeper in frostbite than in the other two diseases. Toes made gangrenous by frostbite are usually gangrenous through their whole cross section, whereas the gangrene of toes in immersion foot, may be only skin deep. Diagnosis within this group of diseases depends largely upon the history of the conditions of the exposure to cold. In diagnosing any of these conditions it is important to be reasonably sure that preexistent arterial disease did not predispose to the damage resulting from exposure to cold.

(11) Coarctation of the aorta should be suspected in all young patients having hypertension, and the pulses in the lower extremities should be palpated in such patients. Hypertension and intermittent claudication in young patients make the diagnosis easy. Final diagnosis results from cardiac examination and radiological examination of the ribs.

(12) Periarteritis nodosa is mentioned only briefly since there are voluminous recent case reports in the literature. Prolonged fever of unknown origin is always a suspect. Intra abdominal manifestations make the patient further suspect. Unfortunately, eosinophilia and subcutaneous nodules are inconsistent manifestations, and diagnosis prior to autopsy is, as a result, unusual. Pulses are usually all present up to the generally fatal outcome. Muscle biopsy from a luckily chosen site will make the diagnosis if it contains the affected small blood vessels.

(13) Ergotism appears to be a great rarity in this country. Ergot intoxication can, however, produce coldness of the extremities, tingling, burning, mus-



le pain, redness and swelling of the digits, and finally cyanosis with numbness and gangrene. The disease occurs in Europe, sometimes in epidemics, when rye grain is infested with ergot fungus. The disease occasionally results from the therapeutic use of ergot preparations in obstetrics. Diagnosis of the disease rests on the history of ingesting ergot and upon the rapid development of the symptoms.

(14) For completeness the diagnosis of arterial aneurysms, angiomata, arteriovenous fistulae, and glomangiomata will be reviewed briefly. The pigmented naevi or birthmarks involve skin and are readily recognizable. A small arteriovenous fistula, is detectable when there is a thrill or a bruit over the fistula, when venous pressure is high locally, or when oxygen saturation of the venous blood is nearly arterial in character. Arteriograms may be necessary to clinch the diagnosis. Large fistulae are more readily recognized by the more striking signs and by the fact that pressure over such a fistula, sufficient to occlude it, reduces the fast pulse

rate. A glomangioma makes itself known to the patient as an exquisitely tender spot, usually on an extremity and frequently beneath a finger nail. The pain from it is severe and may radiate widely. It is known histologically to be a benign hypertrophy of an arteriovenous anastomosis and its nerve supply. Simple aneurysms of peripheral arteries, congenital, luetic, and traumatic, occasionally mimic occlusive arterial disease. Pulses distal to aneurysms may be greatly decreased. Thrombosis within an aneurysm may occlude the vessel. Positive serological tests, a history of trauma, or an abnormally located pulsation, will suggest the diagnosis.

#### SUMMARY

I have chosen the subject of diagnosis of peripheral arterial diseases not because of its being by any means an original one, but because these diseases are still being recognized later than is necessary. Early diagnosis and early therapy are usually effective.

## TUMOR CLINICS OF CONNECTICUT

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**M**ANY YEARS ago the medical profession of Connecticut became dissatisfied with the manner and the methods then in vogue of coping with the cancer problem. Accordingly, in 1933, a committee on tumor study was appointed by the Connecticut State Medical Society, to evaluate the problem of cancer control in the State, and to initiate a program designed to improve the cancer situation.

Under this main committee on tumor study, subcommittees on education, publicity, pathology, treatment and records were set up. This required careful selection of physicians on the basis not only of their interest and experience in cancer work, but also on a geographic basis, so that all sections of the State were represented, rural and urban, and also all creeds, so that sectarian as well as non-sectarian institutions might participate.

Many problems confronted these pioneer committees, and since cancer programs were in their

infancy, they had little to help them in the way of precedents.

First, it was obvious that the intelligent management of the cancer problem could be predicated only on accurate knowledge of what existing conditions really were—how many cancers did we have in the State, how many were dying because of delay in the recognition of the disease, what sort of treatment was being given, and what were the results of this treatment as measured in terms of 5-year cures?

To secure this fundamental information, it was apparent that a standard record form for all cases of malignant diseases in all hospitals must be devised and adopted.

Secondly, it was felt that improvement in the treatment of cancer could be obtained by the development of tumor clinics in hospitals, both large and small, strategically located so that clinics would be easily available to all cancer patients in the State. In

1935, therefore, there was formed an Association of Tumor Clinics whose primary object was not only to encourage the development of tumor clinics but also to coordinate the activities of all clinics and stimulate them to achieve the highest possible standards.

There was considerable controversy at this point as to whether or not such a program should be spread over the whole state or should be centralized in one or two institutions devoted perhaps entirely to cancer work. As a result of an exhaustive survey by the medical profession, the plan of decentralizing cancer activities was thought, rightly or wrongly, to be preferable at that time.

After two years of existence—in 1935—the various committees and the Association of Tumor Clinics felt the need for the establishment of some full time agency which could collect the data accumulating on the standard record forms, and assist the committees in analyzing this data. It was felt that the responsibility of this project should be at least in part assumed by the State itself. Accordingly, the Connecticut State Medical Society, through its Tumor Committees, went before the legislature and obtained an appropriation to finance the establishment within the State Department of Health of a Division of Cancer Research, which has now been functioning for the past eleven years.

In 1940, the Committee on Tumor Study became affiliated with the American Cancer Society after considerable controversy, in true New England tradition.

This brief historical outline is presented because it represents the healthiest form of evolution or growth of a cancer program. It must begin with an interested and awakened medical profession, because no plan can succeed unless physicians themselves are alive to the needs and complexities of the cancer problem, and are willing to band together to assist in solving them. Next, the cooperation of the State becomes necessary, not only in contributing financial assistance to individual clinics, but also in setting up on a full time basis the administrative machinery whereby all vital cancer statistics can be assembled and made available for analysis under the direction of the medical profession. Finally, affiliation with the American Cancer Society becomes inevitable, so that physicians and laymen may participate in its vast educational program, and profit by its magnanimous contribution to so many phases of the cancer field.

If the development of any cancer program fails to coincide closely with this order of events, its success may well be jeopardized at the very start.

In 1933 there were 4 tumor clinics in Connecticut. In 1946 there are 27 tumor clinics in the State, and several more are about ready to function. Each of these clinics is a member of the Connecticut Association of Tumor Clinics, a central organization composed of representatives chosen by each tumor clinic. An Executive Committee elected by these representatives is the active governing body.

The Association of Tumor Clinics has an executive secretary who is a surgeon highly trained in the management of malignant disease, and who, in addition to private practice, visits each tumor clinic periodically to be available for professional advice, and to assist in arranging programs for combined meetings of the various clinics. This executive secretary is a liaison officer among all the clinics of the State, and helps to standardize accepted methods of treatment for cancer of different organs. His part time salary is made available by the Connecticut Cancer Society.

At these periodic meetings of the Association of Tumor Clinics, one clinic in the State plays host to all other clinics, so that a free interchange of ideas is made possible, and an opportunity is afforded to compare results of treatment in both large and small institutions.

The majority of Connecticut Tumor Clinics function with a staff composed of at least one surgeon, one radiologist, and one pathologist. These men see every patient together, so that decisions as to diagnosis and the ideal method of treatment are made jointly in the best interests of the patient. Such physicians are chosen because of their training, experience, and skill in the cancer field, but there are too few in number to be able to cover the much broader field of cancer detection or prevention.

Of invaluable aid to the clinics has been the adoption of standard nomenclature as drawn up by the committee on pathology. In addition, a hand-book on cancer was compiled by leading surgeons, pathologists, and radiologists of the State. Not only has this proved to be a valuable adjunct to the library of the general practitioners of the State, but also the methods of treatment outlined have been used as a guide in all tumor clinics, and has served to introduce a uniformity in therapeutic procedures among the clinics.



More recently, through funds made available by the Federal Government, a plan has been inaugurated whereby three members of each clinic are paid to attend at least four meetings a year of other clinics of the State. The visiting physicians participate actively in the discussions of the host clinic, and it is felt that each clinic will profit by this exchange of personnel. Schedules of these visits are worked out by the Division of Cancer Research of the State Department of Health, and it also is responsible for sending notices of these meetings to all physicians in the area. This is part of a general policy directed at interesting general practitioners of the State in the cancer problem.

In addition, funds to aid tumor clinics are appropriated biennially by the Connecticut State Legislature. Allocation of these funds is based upon a point system which is ingeniously calculated to stimulate each clinic to make careful study of all its cancer cases. The following are the criteria for the determination of points:

	POINTS
For each new patient in attendance	1
Each microscopic specimen	1
Each diagnostic x-ray	1
Each history	1
Each pathological report	1
Follow-up data	1
Data on duration of symptoms	1

The total points earned by each clinic in the course of a year over the total points earned by all clinics, determine the percentage of the total appropriated sum to which each clinic is entitled.

This point system has been responsible to a considerable degree for increasing the percentage of cancer cases proved by microscopic examination, and for obtaining follow-up information on a high percentage of cases—over 92 per cent for all cancer cases in all clinics of the State in the past ten years.

Perhaps one of the greatest achievements of the Connecticut program has been the adoption of a standard record, for use in both hospitals and tumor clinics, and the formation of a registry of these records in the Division of Cancer Research of the State Health Department. On these records, space is provided for all relevant data as to history, physical examination, laboratory findings, treatment, final diagnosis and follow-up. These forms are typed in duplicate, the hospital retaining the original, and the carbon copy being forwarded to the Division of Cancer Research. Here the forms are coded on

punch cards and filed. As the follow-up continues over a period of time, information is again recorded in duplicate, one copy going forward to the cancer registry, and the other copy being retained by the hospital or clinic.

In the past eleven years, Connecticut has accumulated between 35,000 and 40,000 records of cancer cases, over 92 per cent of which have been completely followed. These records constitute today one of the wealthiest sources of cancer information that exists in the entire world.

Medical, and even lay literature, on cancer is apt to be weighted by statistics emanating from our larger clinics and hospitals, staffed, as a rule, by exceptionally competent professional men. Their statistics more often than not apply to selected cases which have been referred to these centers for treatment. They may be interpreted as showing the possibilities of accomplishment in the treatment of cancer, rather than what is actually happening in the vast majority of hospitals to the average patient with cancer.

While it is important to carry on fundamental research into the highly complex factors of the cause and cure of cancer, there is a dearth of reliable information on equally fundamental data relating to the efficacy of presently accepted methods of treatment of malignant disease.

We know, for example, that there is a discouraging delay between the first symptom of cancer observed by the patient, and the institution of definitive treatment, but we have little accurate knowledge of the factors which contribute to this delay.

We all know that many cancer cases are curable, but do we know the curability rate of cancer of various organs compiled from large numbers of hospitals of varying sizes?

All this, and much additional information, can be obtained from such a cancer registry as described above, and it is hoped that States other than Connecticut will elect to establish a similar registry so that basic facts from all over the country can be pooled and analyzed for the common good.

One of the failures of tumor clinics in Connecticut has been the inability, or let us say reluctance, to meet the rapidly growing public demand for a type of clinic that any patient who suspects cancer may enter, without the intermediary formality of reference by either a physician or some social agency. Connecticut tumor clinics, with a few exceptions, will accept only referred patients, and

the service rendered is consultative rather than diagnostic.

Detection clinics have thus far not met with universal approval in the State, chiefly because of the prevailing attitude that every physician's office should be a detection clinic in itself. As a compromise, a plan is being worked out at the present time to establish what will be known as a Cancer Consultative Service. Space and personnel will be allotted to a rotating panel of physicians skilled in the cancer field, who will be available to all patients who feel they may be suffering from cancer. These physicians, after appropriate examination, may refer the patient to a tumor clinic, to the patient's family physician, or to some recognized authority on cancer. The plan is to be set up as an experiment for one year, and will be financed by the Connecticut Cancer Society.

If the need for detection clinics exists, they must be staffed by other physicians who play a less active role in the activities of the tumor clinics themselves. More of the medical men, as contrasted with surgeons, radiologists and pathologists, must participate in detection clinics, because careful examination of apparently well persons reveals an

overwhelming proportion of unsuspected chronic diseases other than cancer. This is true to such a degree it is conceivable that in the course of time the character and goal of these clinics may develop far afield from their original purpose.

Perhaps ideally the tumor clinic should be the foundation or the basic unit in the cancer control plan, and that branches of the tumor clinics for information, detection, education, et cetera, might be developed upon it by augmenting its personnel in social service, administration, and professional work.

Whatever the result, the increasing demand of the public for more careful examinations to detect early cancer suggests that our tumor clinics as constituted, and the majority of practicing physicians, have failed to meet the standards which educational publicity has in a sense created.

Finally, it might be said that cancer control is no longer the responsibility of either the medical profession, the State Health Department, the general hospitals of the State, the American Cancer Society, or the public. It is the responsibility of all of them, and progress can be made only by broad, unselfish, and understanding cooperation among them.

## PROGRESS IN THE TREATMENT OF ALCOHOLISM

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THERE ARE MORE chronic alcoholics in this country today than cases of active tuberculosis. When this fact is considered and the great paucity of treatment facilities is taken into account, it appears that alcoholism is near the top of the list of major public health problems. Limited as these facilities are, the alcoholic today, given proper understanding and rational treatment, has a better than even chance of recovery. Like the psychotic before him he has been until now misunderstood and mistreated, looked down upon and neglected.

Within recent years vigorous and determined attacks on the problems of alcohol have been launched by both scientific and lay groups and significant advances have been made. It seems, therefore, reasonable to hope that with an enlightened interest on the part of the public and the medical

profession, a realization of the progress already made, and a recognition of the urgent need for re-enforcements and support, that a salient may be won and held from which further advances may be made.

Wide popular interest in the problem was aroused by an article in the *Saturday Evening Post* of March 1, 1941, which told the story of "Alcoholics Anonymous," a remarkable group of alcoholics, many of whom had been "hopeless drunkards." This group had its inception in 1935 and has now grown to number some 35,000 members. Hundreds of local units have been formed throughout this country, in Canada, England, Sweden and Australia. The central office, the Alcoholic Foundation, Inc., P. O. Box 459, Grand Central Annex, New York 17, New York, answers inquiries, in confidence, and handles



other correspondence. The office is supported by voluntary contributions from the groups and by proceeds from sale of the book, "Alcoholics Anonymous," written by members. A monthly paper, *The Grapevine*, carries editorials, original articles and news concerning the activities of groups throughout the country, and of the formation of new groups. The growth and success of the movement have been the subject of numerous articles in the popular magazines and in the daily press.

The means to recovery made use of by Alcoholics Anonymous is termed by some a form of religious conversion; but no profession of faith is demanded. The only requirement for admission to the group is "an honest desire to stop drinking." In contrast to orthodox psychiatry, which seeks to uncover the underlying causes, Alcoholics Anonymous attacks the main problem, the inebriety, head on. It is group psychotherapy, by and for the group, but it is more than that. These men and women admit to themselves and to others their helplessness, and in humility, they call upon a Power greater than themselves. Certain it is that those who sincerely accept the precepts and earnestly try to live by them, gain far more than release from their addiction to alcohol.

While the tenets and practices of Alcoholics Anonymous have little relation to science, it is a noteworthy and heartening fact that the group has the wholehearted respect and support of scientists and practitioners of medicine, and mutual cooperation is close and effective. At numerous institutions throughout the country, selected members are permitted, or invited, to act as lay therapists for patients, inmates, or jail prisoners, who have alcohol problems.

The popular interest which this rapidly spreading movement has aroused has served to turn the attention of medical men to the plight of the alcoholic. Alcoholism is coming to be more generally regarded for what it is, a morbid condition responsive to treatment by those possessed of the requisite knowledge and experience: physicians, psychiatrists, or lay therapists. It is first of all a medical problem, but because of the alcoholic's antisocial behavior and his derelictions, it is a social problem as well. Medical men are coming to differentiate between the intoxicated individual who needs only to sleep it off, and the "problem drinker" who requires patient study, sympathetic attention, wise guidance and continuing support.

While the effects of ingested ethyl alcohol upon living tissues and organs have been subjects of laboratory research for many years, the recognition of the alcoholic individual as a patient, in need of medical and psychiatric treatment has not been general until quite recently.

The Research Council on Problems of Alcohol was organized in 1937, and in the following year was accepted by the American Association for the Advancement of Science as an associated society. Its sole purpose, as stated by the Council, is to conduct an unbiased study of the relation of alcohol to the health of the individual, and the welfare of society, and to disseminate the results of its study in a socially useful manner. It is made up primarily of scientists from every field who are interested in the alcohol problem, but it also includes in its membership representatives of religion, government, education, industry and business.

The Council's Study No. I, a report on "The Effects of Alcohol on the Individual" resulted in the publication in 1942, by the Yale University Press, and under the editorship of E. M. Jellinek, sc.d., of the first volume of this report, titled "Alcohol Addiction and Chronic Alcoholism." This is a document of 360 pages, of which one reviewer wrote: "It might well serve as a model for any one who desires to do a critical survey of any specialized field of knowledge," and another, "Leading scientific authorities throughout the country have combined to make this one of the outstanding scientific medical investigations of the last decade . . ."

This basic, comprehensive and lucid exposition of the subject established a point of departure for further investigations in the field and became at once the source book and the authoritative work of reference for research workers and for medical men concerned with the alcohol problem.

A Section on Alcohol Studies was set up in 1940 by the Department of Applied Physiology at Yale, and in June of the same year the *Quarterly Journal of Studies on Alcohol* made its first appearance. This scholarly journal carries original articles, and reviews the current literature appearing in this and foreign countries. The Journal office, in the Department of Applied Physiology, also publishes books and monographs and has printed and distributed many thousands of copies of a series of Lay Supplements dealing with various and varied aspects of the alcohol problem.

A clinical approach based on the new concepts of

the genesis and nature of alcoholism was undertaken with the opening in March, 1944, of the Yale Plan Clinics, one in New Haven and one in Hartford. Cases are handled on an out-patient basis and the service is primarily diagnostic and advisory. However, the quiet and orderly surroundings, the friendly yet professional attitude of the clinic personnel, the manner in which the patient is received, interviewed and examined—so different from what past experience may have led him to expect,—not as a drunkard, but as a sick individual worthy of consideration and respect, these often have a marked therapeutic effect. Moreover, his familial, social and economic status are considered, and adverse elements can oftentimes be ameliorated directly and indirectly. Hospitalization may be advised and arranged for; he may be put in touch with Alcoholics Anonymous or instructed to return for further psychiatric interview and discussion of his problems; or he may be referred to an outside physician for the “conditioned reflex” or “aversion treatment.”

The aversion treatment, as the name implies, brings about through the use of a nauseant drug, a temporary aversion to liquor, which, however, can be maintained by subsequent reinforcements. This procedure may give the well intentioned but inadequate patient a “boost over the hump,” a breathing spell, in which he can adjust to his new alcohol-free way of life. One investigator has this to say regarding the treatment: “The value of the conditioned reflex treatment is not exclusively nor perhaps even chiefly the actual conditioned aversion that is created. Much value seems to reside in the fact that the patient is enlisted in, and commits himself to, an arduous and uncomfortable procedure which impresses him deeply, and has given him the dignity of suffering in a good cause . . . it is something concrete . . . The treatment is a sort of Rubicon which represents an important step to the patient.”

The treatment may hold interesting possibilities for those down-and-out individuals, jailed time after time for drunkenness. These unfortunates have not the moral or intellectual fiber to help themselves. Commutation of the jail sentence, contingent upon the prisoner's agreeing to undergo the “aversion” treatment, might lessen the evils of drink as they afflict both himself and his community.

Without doubt the most immediate and far reaching desiderata, such as the arousing of favorable public sentiment, the propagation of accurate and usable knowledge concerning the varied and com-

plex problems of alcohol, as well as the instigation of individuals and groups to intelligent and effective action, have been achieved by and through the summer sessions of the School of Alcohol Studies.

This school, sponsored by Yale University, through the Laboratory of Applied Physiology held its fourth annual session at New Haven during the four weeks from July 8 through August 2, 1946. One hundred and sixty-one students were enrolled. They came from thirty-seven states, the District of Columbia and from Canada.

The following is taken from the school's prospectus—“The object of the summer sessions is to make the most recent findings of scientific research available for application to the problems of alcohol in the community.”

“The aim of the school is to communicate authoritative scientific information to those whose daily activities bring them into closer contact with the general public than the scientist achieves and who are qualified to process the knowledge which scientists impart to them for the purpose of general consumption.”

The success of the clinics at Hartford and New Haven and the activities of the Yale School of Alcohol Studies aroused the interest of citizens throughout the state in the problems of alcohol. There was growing recognition of the magnitude and gravity of the situation. The fact that in most communities the only public institution willing to accept an alcoholic is the jail took on new significance and pointed up the deplorable situation of the three-quarters of a million chronic alcoholics in this country.

Growing public sentiment in favor of some definite remedial action found expression in the creation, at the 1945 session of the General Legislative Assembly of a Board of Trustees, of the State Fund for Inebriates. In December, Governor Baldwin appointed the following members of the Board: Selden D. Bacon, PH.D., chairman; Thomas P. Murdock, M.D., vice-chairman; Mrs. Edna A. F. Edgerton, secretary; Arthur H. Jackson, M.D.; Abraham S. Ullman, attorney.

The Board has engaged the services of Dudley P. Miller, PH.D., formerly assistant director of the New Haven Hospital, as its executive director. Administrative headquarters were opened on March 15, 1946, at 110 Whitney Avenue, New Haven. The Board's immediate plans call for the appointment of a medical director who will be responsible for



organizing and coordinating the efforts of the program's professional personnel. The following report has been provided by Dr. Miller:

"The basic purpose of the Board is, through the use of clinics and other facilities, to provide diagnostic and treatment services for alcoholics, to study the problems of alcoholism and to disseminate information on this subject. Nine per cent of the fees for permits received by the Liquor Control Commission will be used annually to support the Board's activities.

The Board opened its first clinic in Hartford on July 1. The services of the Yale Plan Clinic have been secured through a contractual arrangement whereby full clinic services are available to patients from the New Haven area referred to the clinic by the Board.

In addition, clinics in the major population centers of the state are envisaged, within budget limitations and will be established as fast as arrangements can be made and personnel secured. These facilities are designed to provide professional services for alcoholics on an out-patient basis. The professional personnel of such clinics will consist of a psychiatrist, two psychiatric social case workers, and the consulting services of a psychologist, a general physician and special hospital facilities.

Plans for the establishment of convalescent units for those patients needing more than ambulatory care for a limited period of time, and a facility for the commitment of alcoholics by courts, are proceeding hand in hand with plans for the establishment of out-patient facilities.

The Board expects to establish close contact with hospitals and with private, municipal and State social agencies, and to develop relationships with these

resources that will be of mutual benefit in caring for the alcoholic and members of his family."

Thus an important milestone has been reached. It could hardly have been reached at this time without the arduous and painstaking labors of the group of scientists at Yale, and their associates, whose fundamental and comprehensive studies established a foundation of basic knowledge of this problem.

In the mind of an earnest and determined minority the alcohol problem and the liquor evil are one. A large number will see truth or reason in the dictum of Dr. Karl A. Menninger who states:

"There is much to indicate that in our civilization alcohol has a very useful function to perform, and may be a source of increased happiness and decreased hostilities."

A problem of such protean nature is hardly to be resolved to the general satisfaction of all. Rather the summum bonum is to be sought through education, and through the wide dissemination of accurate, intelligible and relevant information. Its authenticity must be such that none may reject or ignore it save on pain of being suspect.

Drinking must be divested of its glamour and romance, its mystery and daring, which so subtly appeals to youth. What is called for is not august pronouncements, ex cathedra, or a recounting of dread potentialities; rather, a presentation of the evidence, interesting, logical, and worthy of the innate intelligence and healthy curiosity of the student. Thus may he come to know that alcohol, like fire, can be for him who understands it and keeps watch upon it, a good servant. But that he who too often and too lightly seeks refuge in its cheering warmth shall find it a hard, insatiable, destroying master.

## MEDICAL PROGRAM AT NEWINGTON VETERANS HOSPITAL

LEWIS G. BEARDSLEY, M.D., *Newington*

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The Author. *Manager, Veterans Administration Hospital, Newington*

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THE PRIMARY objective of all Veterans Administration Hospitals is to provide the highest possible standard of medical care for ex-service men and women of the country entitled to and in need

of such services. In addition to meeting this obligation, the Veterans Administration, through its Department of Medicine and Surgery, established January 3, 1946, under Public Law 293, has developed an extensive Resident Training Program in many of its hospitals. Physicians throughout the State should be interested in knowing that the Vet-

erans Hospital at Newington, Connecticut, has been selected as one of these Teaching and Training Centers.

In accordance with the policy of the Veterans Administration to utilize the services of Medical Schools in organizing and carrying on these training programs, the authorities of the Yale University School of Medicine agreed to sponsor the program at Newington under direction of the Dean's Committee of which Dr. Francis G. Blake is chairman.

The first step in developing this program has been to staff and equip the hospital to a standard acceptable to the various American Specialty Boards. Full time Board members have been placed in charge of the medical, surgical, neuropsychiatric, x-ray services, and pathological laboratory. The necessary structural requirements have been accomplished and modern medical equipment has been installed. Approval of the hospital for residency training in medicine and surgery has been requested and is being given consideration by the respective Boards.

There are listed below the consultants, attendings and residents who have been selected by the Dean's Committee and the full time medical staff which has been approved by this committee.

#### FULL TIME STAFF

Brandriss, Dr. Joseph	Ear, Nose and Throat
Cressy, Dr. Norman L.	
	Assistant Chief, Medical Service
Ferriter, Dr. Thomas	Anesthesiologist
Flashman, Dr. David H.	Pathologist
Gurwitz, Dr. Jack	Assistant Chief, Surgical Service
Hurwitz, Dr. Alfred	Chief, Surgical Service
Kunkel, Dr. Paul	Chief, Medical Service
Levy, Dr. Jack H.	Roentgenologist
Pollock, Dr. Henry M.	Urologist
Schnap, Dr. Isidore	Chief, Neuropsychiatric Service
Selesnick, Dr. Sydney	
	Assistant to Chief, Medical Service

#### CONSULTANTS

Birge, Dr. Henry L.	Ophthalmology
Canfield, Dr. Norton	Otolaryngology
Curtis, Dr. Burr H.	Orthopedics
Deming, Dr. Clyde	Urology
Fox, Dr. James C.	Neurology
German, Dr. William J.	Neurosurgery
Harvey, Dr. Samuel C.	Surgery
Klatskin, Dr. Gerald	Medicine
Lindskog, Dr. Gustaf	Thoracic Surgery
Pike, Dr. Maurice	Orthopedics

Scoville, Dr. William H.  
Schumacker, Jr., Dr. Harris B.  
Taffel, Dr. Max  
Tovell, Dr. Ralph M.  
Tucker, Dr. Dan  
Whitcombe, Dr. Benjamin  
White, Dr. Benjamin V.  
Wilson, Dr. Hugh

Neurosurgery  
Surgery  
Surgery  
Anesthesiology  
Radiology  
Neurosurgery  
Gastroenterology  
Radiology

#### ATTENDINGS

Barbour, Jr., Dr. Charles M.  
Berneike, Dr. Robert E.  
Bingham, Dr. Charles T.  
Bishop, Dr. Courtney C.  
Claiborn, Dr. Louis  
Glorig, Dr. Aram  
Janzen, Dr. Arnold H.  
Jordan, Dr. Robert H.  
Kaplan, Dr. Henry S.  
Nichols, Dr. Edward  
Schwartz, Dr. Herbert  
Smith, Dr. Wilson F.  
Twaddle, Dr. Paul H.

Anesthesiology  
Urology  
Medicine  
Surgery  
Surgery  
Otolaryngology  
Radiology  
Medicine  
Radiology  
Medicine  
Ophthalmology  
Medicine  
Medicine

#### RESIDENTS

Berger, Dr. Alfred J.  
Cohen, Dr. Manley B.  
Conforti, Dr. Victor P.  
Dana, Dr. Jacob B.  
Fay, Dr. Kevin  
Healy, Dr. Thomas M.  
Jones, Dr. Cyril J.  
Katzin, Dr. Benjamin  
Lahey, Dr. William J.  
Leventhal, Dr. Louis  
Lockward, Dr. Howard J.  
Lovell, Dr. Charles V.  
Lundberg, Dr. Einar A.  
Ossen, Dr. Paul I.  
Parella, Dr. Giocchino S.  
Rowles, Dr. William S.  
Scherbel, Dr. Arthur L.  
Sherwood, Dr. Paul M.  
Simkin, Dr. Stanley  
Slataper, Dr. Eugene L.  
Storey, Dr. Charles M.  
Tannheimer, Dr. John F.

Medicine  
Surgery  
Surgery  
Medicine  
Medicine  
Surgery  
Surgery  
Medicine  
Medicine  
Surgery  
Medicine  
Medicine  
Medicine  
Medicine  
Medicine  
Surgery  
Surgery  
Medicine  
Medicine  
Surgery  
Anesthesiology  
Medicine  
Medicine

Residents are citizens of the United States, Veterans of World War II, graduates of approved Schools of Medicine, have completed an internship acceptable to the Administrator, desire to complete requirements for Specialty Board certification, and



have been approved by the Dean's Committee.

The full time medical staff is responsible for the care and treatment of the patients, obtaining consultations, advice and assistance from the Consulting and Attending Staffs as indicated.

Consultants act in a consulting and advisory capacity to the Chiefs of Services, furnishing the benefit of their professional experience and counsel. They assist the Chiefs of Services in organizing the medical work, are available for consultation in matters relating to their specialties, and play a prominent role in the conduct of clinics, conferences, ward rounds and in the teaching and training of residents.

The Attending Staff assists in the immediate care of patients and in the Resident Training Program by demonstrations, frequent conferences and routine ward rounds with members of the Resident Staff.

In those instances where the hospital is unable to provide all the training requirements in certain specialties, provision is made for this through affiliation with outside hospitals, schools or clinics.

In addition to furnishing excellent medical care to patients and conducting a teaching and training program for Residents, the hospital is carrying on an expanding research program which should prove of benefit not only to veterans but to the medical profession as a whole.

The hospital has 334 official beds and a limited number of extra beds which can be made available if needed. With the present staff and equipment it is possible to treat practically all types of general medical and surgical conditions occurring in both ex-service men and women, and the accelerated program makes it possible to render prompt care to those entitled to and in need of such.

## THE ROOMING-IN PLAN FOR MOTHERS AND NEWBORN INFANTS

EDITH B. JACKSON, M.D., and HERBERT THOMS, M.D., *New Haven*

**R**OOMING-IN is a term applied to that form of hospitalization where mother and newborn baby room together and in which the mother takes as much care of the baby as possible. During the past four months (since October 29, 1946) at the New Haven Hospital, for purposes of evaluation, this system has been carried out in a four-bed unit adapted for the purpose.\* Although it is considerably too early to comment upon the results of the experience, it seems timely, in view of the interest in the project, to consider some of the thinking which led to its inauguration. Rooming-in is not a new procedure, as our grandparents could well tell us, and in certain European countries it still exists in its essentials in many modern hospitals. In this country this natural arrangement was abandoned in favor of the hospital nursery, which was developed to improve standards of infant health, an attainment realized to a very great degree. That the present system may have disadvantages from a psychological point of view is the belief of many who think that

the hospital nursery separation of the infant from its mother may interfere with certain essential psychological needs of both mother and child, and that a return to the rooming-in plan will prove an important step in counteracting the over emphasis on strict regulation of infant care which the present system tends to promote.<sup>1</sup>

Some reasons for this change of thinking in favor of rooming-in may be considered. About ten years ago one of the authors (E.B.J.), while working as psychiatric consultant to the Department of Pediatrics became impressed with the fact that the regimentation of feeding schedules for infants, especially when followed by early emphasis on training in regularity of toilet functions, had apparent relationship to children's behavior difficulties and also to parents' conflicts with children in trying to manage such difficulties.<sup>2</sup> It was observed that, because of a strong feeling of responsibility to follow medical advice, frequently parents were afraid to be natural in their feelings toward the child and to the child's apparent needs. It was noted during this study that one of the major difficulties of re-

\*This project is being aided by a grant from the Mead Johnson Company.

cently delivered mothers was in their adjustment from a systematized hospital life to the more unsettled and demanding home situation, and to the baby's irregular cries. The primary interest in the rooming-in of mother and babies has a direct relation to observations of this kind.

In 1942 an important contribution to the subject was made by Simsarian and McLendon,<sup>3</sup> who reported on "The Feeding Behavior of an Infant During the First Twelve Weeks of Life on a Self-Demand Schedule." In 1945 these same authors<sup>4</sup> reported on "Further Records of the Self-Demand Schedule in Infant Feedings." In this same year McLendon and Parks<sup>5</sup> published "Nurseries Designed for Modern Maternity" which gave an account of the plans for rooming-in units in the new George Washington University Hospital, now under construction. More recently Moloney, Montgomery, and Trainham,<sup>6</sup> writing in *Modern Hospital* for December 1946, state "When mother and baby room together and the mother takes over as much care of the baby as possible, she not only satisfies her driving need to feel useful to her infant but also through practice and supervision in the care of the baby, diapering and bathing as well as feeding, she acquires a complete confidence in her ability to care for him and a considerable skill in doing so. She also has opportunity to know her baby and to learn to interpret his demands for nursing care and how to meet them." These authors also believe that the infant kept at his mother's side is safer from infections, gastro-intestinal, respiratory, and dermal, than is the infant in the crowded hospital nursery.

Another point which has been emphasized by advocates of the plan is that the proximity of mothers and newborn infants may increase the American mother's wish and ability to breast feed, both of which seem to be remarkably on the decline. From the obstetric point of view the favorable effect of maternal nursing upon the physiology of the puerperium is well known. In addition, a mother who from the beginning is happy and interested in her baby, and whose hospital stay is an interesting and absorbing experience, cannot help but be bene-

fitted by the well being which thus has been promoted.

Although the experience at New Haven is too new for analysis, on the basis of preliminary observation it is believed that through limitation of visitors to one member of the family at a time, the instruction of visitors in isolation precautions, and the supplying of the mother with appropriate means for cleansing her hands before handling the baby, satisfactory control of sources of infection can be maintained without undue artificiality. Although figures are not available at this time, it may be that the actual demand on nursing service is decreased rather than increased because some mothers are ready to assume the principal care of the baby after the second day.

It is obvious that, because of the nature of the project, it has been necessary to exercise some controls on inspection by persons interested in this newer type of hospital care. Nevertheless, there seems to be a general opinion expressed by those who have witnessed rooming-in that its consideration in future hospital planning and administration cannot be neglected. Finally, it must be recognized by all who contribute to maternity service that "the period of hospitalization of mother and newborn baby offers a great opportunity to give the new mother instruction in child care and to stimulate her interest in child development. It should also be a time to help her become familiar with her baby, to assist her in the establishment of breast feeding, and to reinforce her confidence in approaching her new responsibilities and enjoyment of her new opportunities."<sup>4</sup>

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## WATERBURY HOSPITAL CLINICAL PATHOLOGICAL CONFERENCE

J. O. COLLINS, M.D., *Waterbury*

A WHITE female infant weighing 6 lbs., 3 oz., was delivered at the Waterbury Hospital by low forceps in June 1942, and cried lustily immediately after delivery. Color was good. Baby was breast-fed and nursed well but failed to gain weight. Was discharged on the eleventh hospital day, weighing 5 lbs., 14 oz.

Was readmitted to the hospital at the age of 10 months complaining of persistent cough and a cold which had been present for past 2 months. Had received sulfa drug on the outside without benefit. During the week before admission the cough was quite troublesome and spasmodic, followed by vomiting. The mother stated that since birth the baby had had considerable indigestion with 5 or more loose, foul smelling stools daily but the stools seemed to be getting firmer of late. Had been breast-fed for 3 months after delivery and at the time of second admission was taking egg yolks, pabulum, milk, vegetables and banana.

On physical examination the child appeared thin and undernourished. There were frequent spasms of coughing. Head and neck were not remarkable. Throat was injected. No palpable adenopathy. Chest was resonant throughout with a few rales in the right base. Heart rapid but with no murmurs. Abdomen distended and tympanitic. No masses palpable. Extremities revealed no edema, no Kernig, no nuchal rigidity, no Babinski. There was a fine fading rash over the chest and abdomen and forehead.

X-ray of the chest showed increased lung markings with mottling throughout the greater parts of both lung fields, consistent with broncho-pneumonia.

Urine on admission showed 6 white cells per low power field. Admission blood count revealed Hgb. 11 grams; RBC 4.1; WBC 13,000 with normal differential count. A throat culture was negative for hemolytic strep or hemophilic bacilli. A stool examination showed a semi-solid, light yellow stool in

which fat was excessive. It was negative for occult blood. A second stool examination showed excessive fat.

Temperature on admission was 100 and during the stay in the hospital varied from 98 to 104. The baby weighed 15 lbs. 11 oz. on admission.

During its stay in the hospital the baby took feedings poorly, continued to cough and continued to have diarrhea with foul smelling, loose stools. Was treated with nose drops, forced fluids and sulfathiazole. Received repeated clyses. Continued to go downhill and died 9 days after admission.

## DIFFERENTIAL DIAGNOSIS

Dr. John Standard: The story is that of a ten month old female child who failed to gain weight properly despite an adequate diet and good appetite. Shortly after birth the mother noted that the child had indigestion and several loose foul smelling stools daily. The child admitted to the hospital for persistent cough of two months' duration. The physical examination revealed nothing of note except a fading rash to which little significance could be attached. X-ray examination of the chest reveals a bronchopneumonia. The most significant laboratory examination was the finding of the stools containing excessive fat. Despite apparently adequate therapy the child continued to go downhill and died.

In the differential diagnosis one must consider bronchiectasis, celiac disease and cystic fibrosis of the pancreas. Although the respiratory involvement was undoubtedly the cause of death it seems secondary to the underlying gastrointestinal pathology which predisposed the child to intercurrent pulmonary infection which eventually caused her death.

The bronchopneumonia which was found present on admission was undoubtedly secondary to some underlying pulmonary pathology. The history fails to reveal any evidence of pertussis which in children may bring about an interstitial pulmonary involve-

ment with subsequent bronchiectasis. Although there is no history of inoculation with pertussis vaccine it is safe to assume that the child did not have pertussis.

Celiac disease is a clinical syndrome and not a disease entity. It is a chronic disturbance of nutrition characterized by a large protruding abdomen, attacks of diarrhea with large pale, foul smelling stools and anorexia. It is rarely encountered before the end of the first year and it is more frequently seen during the second and third years. It may develop at any time during childhood. The difficulty in these patients is one of absorption and of necessity would bring about deficiency diseases. Because of the poor absorption of the fat soluble vitamins (A and D) there may be rickets or conditions associated with Vitamin A deficiency, such as frequent colds and xerophthalmia. However, despite the obvious faulty intestinal assimilation, all the pancreatic enzymes can be demonstrated after duodenal intubation. Although duodenal intubation and examination for pancreatic enzymes was not done in this case, I feel that we are not dealing with a pure celiac syndrome but a celiac syndrome secondary to cystic fibrosis of the pancreas.

This case follows the usual protocol of a case of cystic fibrosis of the pancreas namely, an early onset, failure to gain weight on an adequate diet, hunger, large foul stools and a tendency to chronic respiratory infections.

This disease is present at birth, is questionably familial and occurs equally in both sexes. Those affected usually succumb before the first year of life. Stools are abnormal from birth as in this case. It is felt that it is improbable that the nutritional difficulty originates after birth. There is usually other associated abnormalities of the intestinal tract such as biliary cirrhosis, or hypoplasia of the extra hepatic biliary system. There is a high susceptibility to the respiratory infections in this disease. The pulmonary lesions may be due to congenital bronchiectasis, vitamin deficiencies, secondary to steatorrhea or to an abnormality in the bronchial secretions similar to that believed to cause pancreatic lesions.

Laboratory studies reveal a low cholesterol, a flat curve in the glucose tolerance test, a poor absorption of vitamin A—a normal absorption is evidence against this disease—and the absence of pancreatic enzymes in the duodenal contents.

Although the above mentioned studies were not done in this case we can make the diagnosis of

cystic fibrosis of the pancreas on the criteria set forth by Daniel namely, failure to gain weight, respiratory distress, large fatty homogenous foul smelling stools.

My diagnosis therefore is:

1. Cystic fibrosis of the pancreas.
2. Bronchiectasis with an associated bronchopneumonia.

#### CLINICAL DIAGNOSIS

Cystic fibrosis of pancreas.  
Bronchopneumonia.  
Malnutrition.

#### DR. STANDARD'S DIAGNOSIS

Cystic fibrosis of pancreas.  
Bronchiectasis.  
Bronchopneumonia.  
Malnutrition.

#### PATHOLOGICAL DIAGNOSIS

Cystic fibrosis of pancreas.  
Hypoplasia of gall bladder.  
Bronchopneumonia and bronchiectasis.  
Malnutrition.

#### PATHOLOGICAL DISCUSSION

Dr. Collins: Despite the paucity of information recorded in the protocol, both the attending pediatrician and Dr. Standard were able to arrive at the correct diagnosis. The gross autopsy findings were not very striking. There were numerous small patches of consolidation throughout both lungs as correctly noted by Dr. Harvey in x-ray examination of the chest. The lung tissue between the consolidated patches seemed well aerated. The liver was not remarkable but the gall bladder was very tiny and contained a small amount of inspissated mucoid material. The extrahepatic biliary ducts seemed normal. The pancreas was small and hard but no cysts were noted grossly. In fact, considerable time was spent in a futile search for the pancreatic duct. It could not be demonstrated on gross transverse section of the pancreas or in the ampulla of Vater. However, in the microscopic sections of pancreas and lungs one sees a striking picture. Here projected on the screen (demonstrating) is a section of pancreas. The ducts are there, they are somewhat dilated, and they are filled with inspissated amorphous debris. The parenchyma of the gland is almost totally replaced by fibrous tissue so that few glandular acini remain. Islets of Langerhans appear unaltered except that they stand out more prominently.



ently and appear more numerous because of the absence of obscuring glandular parenchyma and because of shrinkage of the fibrous tissue. Here (demonstrating) is a section of lung. Bronchioles are dilated and filled with purulent exudate. Alveoli immediately around the smaller bronchii and bronchioles are filled with exudate. The non consolidated areas show a tendency to emphysema with some rupture of alveolar walls. This may be an unusual phenomenon.

Inasmuch as the autopsy was limited to an abdominal incision, salivary glands were not obtained for examination. They may show a type of involvement similar to that in the pancreas. In fact, an attractive theory as to etiology of this condition conceives of some chemical-metabolic disturbance which results in the formation by all secretory cells of a secretion

so thick and viscid that it does not pass readily through ducts and so tends to plug them up. Meconium ileus has been explained on a similar etiologic basis. Those of you who wish to pursue the subject farther are referred to articles by Andersen,<sup>1</sup> Farber,<sup>2</sup> and Harper.<sup>3</sup>

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## PSYCHOSOMATIC ELEMENTS — WHEN THE FOREMAN IS A PAIN IN THE NECK

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The Author. *President and Psychiatrist-in-Chief,  
The Institute of Living, Hartford, Connecticut*

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"**T**HAT FOREMAN gives me a pain in the neck!" There is nothing new or hard to understand about that descriptive, if not too refined, emotional outburst of the attitude entertained by some workers toward a superior. In the vast majority of instances, the plain-spoken employee is only exercising a figure of speech, enjoying a venting of the spleen, so to say, but no informed person can deny that sometimes that pain in the neck is a reality which springs from an emotional tension and resultant antagonism caused by the employee's inability to adjust.

If you do not believe that emotional tension can cause a pain in the neck, you should try driving a car against glaring headlights for a stretch of 500 miles, even under normal driving conditions, to see if the back of your neck does not ache at the end

of the trip. Yet, I doubt if many drivers actually steer with the back of the neck. The pain is caused by *emotional tension*. Specific data is available to prove that emotional upsets play an important part in physical complaints, and to the degree with which those complaints interfere with the worker's productivity, industry cannot afford to neglect them.

It would be presumptuous to claim that 95 per cent, or 50 per cent, or even 25 per cent of all absenteeism or accidents originate in emotional disturbances; or to jump to the conclusion that our present day understanding of human emotions is the panacea for all problems of production. Nevertheless, if a better understanding of the human emotions as they relate to the factory could contribute 3 per cent, or 2 per cent, or 1 per cent to productivity, it might mean the difference between profit and loss for the company.

I am lowbrow enough to subscribe to the thesis that industry is still organized for profit, and, as I understand it, profit is an easily vanishing thing, now only

a small percentage of the total income, which is left after costs of materials have been paid and deductions for payrolls and taxes have been made. In the age of keen competition and "dog eat dog" period which appears to lie ahead, the margin between profit and loss is destined to be narrow, and may even disappear. We do not mean to make a great "production mountain" out of the importance of human emotions in the factory, but they are certainly more than a molehill in determining the difference between profit and loss.

Human beings have always struggled through the morass of trying to get along with each other, and in the process, they have established *interpersonal relationships* which at times have been most profitable and congenial, but at other times have been most unprofitable and most uncongenial. With good interpersonal relationships, people have a belief in their own ability and a desire for accomplishment. *As a result, they produce.* With poor interpersonal relationships, the reverse is true.

History proffers many striking examples of greater numbers being defeated by smaller numbers when the smaller numbers had the advantage of a satisfying emotional adjustment and common emotional objectives. Napoleon Bonaparte, who was capable of creating in large groups of people the desire to produce and the desire to deliver, may be said to be one of the forerunners of present day production experts. His successes can be largely attributed to his ability to develop that all determining factor of the *emotional drive*, which, translated into present day production terms, is the *will to do* of the employee. Not only production experts, but many labor leaders have attained startling success through their understanding of these simple facts.

As doctors, we are not professionally interested in any of the ideologies or disputes which give birth to C.I.O. or A.F.L. controversies. However, as medical men, we are concerned with the worker's reaction from the standpoint of medicine and practical reality.

Those who are familiar with the history of England and the so-called industrial revolution understand that English industrialists felt the necessity to produce on a "survival basis." Somewhat erroneously it was thought that without the taskmaster foreman of yesteryear and yestercentury, England would have succumbed to the superior agriculture and natural resources of the continent. On that

"survival level" the worker had no alternative other than to accept the foreman of the day in keeping with the spirit of the times, which relegated the workman to the status of a commodity instead of allowing him his rightful position as a stockholder in society. However, without apologies for the foreman of yesteryear and yestercentury, we must admit that neither management nor the foreman remained static, and, therefore, we might do well to look at the past as the evolution of an industrial Darwinian theory.

If we go to Tennessee and become fundamentalists, our battle is lost even before it starts, but if we remain in Massachusetts where a recently enacted law provides 60 cents an hour and \$24 a week as the minimum wage for survival, we must become industrial Darwinian students.

We in this country have passed from the era of survival into an era of plenty, an era characterized by a benignity which regards other parts of the world as less fortunate and less advanced.

In 1915, when I made my bow to medicine, and now I confess my antiquity, the great discovery was being made that for best results a man's physical capacities must be matched to the requirements of the job, and the importance of matching his educational and intellectual attributes to the job was beginning to be recognized. Since then the importance of emotional capacities and attributes has been brought to the fore, but before the catastrophe of the last war the emotional factor was recognized only to a certain and very limited extent.

It took the Germans and possibly the Russians to teach us the importance of developing the will to do, and we must admit that they most forcibly demonstrated to us the potency of a common emotional drive in attaining a desired objective. Without becoming involved in foreign policy, we may find a survey of individual and mass incentivitation in other parts of the world to be very revealing. Certainly if we study trends in the development of individual and mass emotional drives in certain districts, there will be no doubt left in our minds as to the importance of the emotional factors in handling individuals and groups.

Even the ancients recognized the relationship between attitudes and emotional drives and the physical self, and recorded the fact, like many if not most aspects of human nature, in vulgar or slang expressions which have obtained to this day. "He



as no intestinal fortitude" shows an underlying anxiety and fear resulting in a certain looseness or upset of the intestinal tract with accompanying disastrous results. Another example is "my heart's in my mouth," indicating an anxiety or stress which causes a pounding of the carotid arteries in the neck with an increase of vascular tensions.

Thus, we return to our original thesis of the foreman and a certain relatively small but nonetheless vital percentage of persons in industry who are really giving "a pain in the neck" to producing workers.

We know that some physical conditions have purely emotional causation. It has been established that dogs, or men, can be made so unhappy that they develop gastric ulcers and are incapacitated by lack of control over normal body functions, with possible fatal outcome. In my experience, I have seen gastric upsets, backaches, headaches, or what have you, which would not have obtained had the individual's emotional attributes been matched to the job and his interest level been high enough.

An understanding of emotional attributes and interest level has been shown to be indispensable to maximum production, and we must bear in mind the fact that the relationships of the worker on the firing line are of primary importance.

When the relationships between the employee and the foreman or the conditions of the job are such that the worker cannot meet the demands, one of three things will happen inevitably: (1) he will throw up the job and everything else and quit; (2) he will project his sense of inadequacy and discontent in a visible dissatisfaction with and criticism of the job conditions and his fellow workers which is infectious and damaging to industry; or (3) he will get sick. In any of these situations, he will not have a high interest level, he will not have the will to do, and subsequently, he will not produce at his maximum capacity.

The fact remains that the doctor or the foreman who knows whether his patient or his worker needs encouragement or a good shove for incantation is a production genius.

So it is that I suggest encouraging the foreman to become a student of human nature and to gain experience in developing the will to do, which brings us to the necessity of educating the foreman of today instead of following in the footsteps of the foreman of yesteryear and yestercentury.

First and foremost, the foreman *must be a teacher*. I pause to bow to my own past when I attained to the position of professor. When I became one, I was ashamed to admit it. Yet, whether or not the idea appeals to us, the foreman of today and of tomorrow must have two qualities: (1) he must be a teacher; and (2) he must be an expert in understanding emotional drives and the will to do.

Let me add two notes of caution. First, one thing is certain: unless the higher echelon of management carries out this concept, there is not a Chinaman's chance for the foreman, even if that foreman has a full appreciation of the importance of the emotional adjustment of the worker. Any program which is set up must be the cooperative effort of the medical department, management, and the foreman. Secondly, we must carefully avoid formulating any set pattern to be applied to all workers. No thesis which regards all employees as being emotionally the same can possibly succeed until all babies are born in a standard pattern of one mother and one father, which is entirely improbable, at least within the next few generations.

At the moment, another point for concern is embodied in the smaller factories. I have been closely connected with great industrial plants in this country, and I have recently returned from dining and wining in England with the most astute, topflight men in the management of Lever Brothers, which has world wide contacts. These large companies, such as Lever Brothers and General Motors, are setting themselves on the right path, but the smaller plants, although they are becoming conscious of the importance of emotional factors involved in industry, have no visible means of carrying out an adequate program. The situation is disturbing in the light of statistics recorded by Dr. J. G. Townsend, medical director of the United States Public Health Service in Bethesda, Maryland, according to whom about 98 per cent of our entire industrial establishments are smaller plants which employ approximately 60 per cent of our entire industrial working force. Some of them are getting together on medical programs, but the emotional side of their personnel problems is very largely being neglected.

We cannot think in terms of a magic psychiatric wand, or of a psychiatric prescription to cure all ills to which the human flesh is heir. The fact is that there is no prescription. Psychiatry has no secret pill nor any formula. We only have the applica-

tion of principles to offer.

I repeat that it would be presumptuous to assert that 95 per cent, or 50 per cent, or even 25 per cent of all absenteeism or accidents have their origin in emotional causes. Nevertheless, if only 4 per cent, or 3 per cent, or only 2 per cent do originate from emotional causes, industry *cannot afford to neglect them*.

We know that gastric ulcer, headaches, back pains, and so forth come to the surface with the dropping of the individual worker's interest level, but it is still to be determined absolutely that the vast majority of these physical manifestations have causation in underlying anxieties. Accident proneness has been one of the most tangible problems, but even this still must be subjected to the assault of clinical experience. Furthermore, the claims that certain personality types can be identified with these incapacitations are largely speculative and have yet to be demonstrated scientifically. Considerable evidence points to this idea, but industrialists are a hard headed lot, and quite rightfully, they maintain a "show me" attitude. The study of personality types as a part of job placement is a long but promising field for industry to investigate.

The brutally realistic circumstances of war and, I might add, its aftermath have taught both executives and doctors that there is a close relationship between an individual's physical incapacities and his emotional attitudes. Now, it is the task of those interested in industry to salvage this knowledge and apply it in the interests of management and the worker alike.

Two dangers arise from the fact that a worker can be physically incapacitated as a result of purely emotional causes.

One danger is that the over enthusiastic will assume an emotional causation for "all the ills to which human flesh is heir," when those ills are found in industry. It would be easy in these turbulent and highly restless times to go to the extreme of charging everything from an ingrown toenail to baldness

to poor job placement, quarrels at homes which disturb the worker's piece of mind while on the job, feelings of frustration on the job, and so forth and so on.

The second danger is that of going to the other extreme, rejecting the relationship between the emotions and disability as just so much poppycock since industry has seemed to get along very well for 50 to 100 years without any such nonsense. Such a stand is not tenable in the light of hard headed scientific experiments which have proven that purely emotional factors can produce a number of gastric ulcers.

Such a stand is not tenable in the light of investigation which shows that heart and blood vessel diseases, including coronary attacks, and eye and back conditions have their origin sometimes wholly sometimes partly in emotional strains or attitudes. In hard headed, scientific laboratories, we have learned that the cure for a considerable number of these physical conditions is found solely in handling the emotional side of man.

There is one thing more. May I assure you that in all of my remarks, I have been referring at once to the top flight executive as well as to the worker. Do not assume that I have been talking exclusively about the worker at the bench and in the lower income brackets, for I have found in my 38 years in psychiatry and industry and executive positions that the top flight executives are as just as, if not more, frequently involved in and vulnerable to these body mind illnesses than are the more modestly compensated. All ranks and groups of workers furnish their quota to the so-called psychosomatic disabilities.

In conclusion, let me say that man has a mind and man has a body. The two are so intermingled and so interdependent that they are one. Emotions will cause a man's heart to pound and a woman's face to blush, facts which were well known by the ancients and now are only being rediscovered by us. As we think this over it is time for us to blush!



## 155TH ANNUAL MEETING PRELIMINARY ANNOUNCEMENT

The 155th annual meeting of the Society will be held at Hamden High School Tuesday and Wednesday, April 29 and 30.

The House of Delegates will meet all day on Monday, April 28, at the New Haven Medical Association, 64 Whitney Avenue.



HAMDEN HIGH SCHOOL

The committee arranging the annual meeting includes the following members of the New Haven County Medical Association: John H. Bumstead, chairman; Dennis S. O'Connor, Frederick W. Roberts, Maurice J. Strauss. Ex-officio members are: M. Heminway Merriman, association president; Ralph E. McDonnell, vice-president; Herbert

Thoms, councillor and Courtney C. Bishop, clerk.

The program for this meeting is being planned by the Society's program committee, members of which are William H. Resnik, chairman, of Stamford; Samuel C. Harvey and Carl E. Johnson, both of New Haven. John F. Fulton, of New Haven, is associate member of the committee.



WILLIAM R. RESNICK, M.D.

Preliminary Program Announcement

- Guest speakers will present their papers each morning. Symposia and section meetings will be held each afternoon.
- Woman's Auxiliary will meet in New Haven Tuesday, April 29.
- Annual banquet of the Society will be held at the New Haven Lawn Club Tuesday, April 29.
- Luncheons during the annual meeting will be served in the cafeteria of Hamden High School.
- The House of Delegates will be guests of the Society at a luncheon at the New Haven Medical Association on Monday, April 28.
- Convocation of the Society and introduction of new officers on Wednesday afternoon, April 30.

Technical exhibits have been arranged with Mr. Frank L. McDonnell, of E. L. Washburn and Company, Inc., and the following exhibitors:

<i>Space Number</i>	<i>Firm</i>	<i>Location</i>
1	H. J. Heinz Company	Pittsburgh
2	E. R. Squibb and Sons	New York
3 and 4	L. & B. Reiner	New York
5	Spencer, Incorporated	New Haven
6	Nestle's Milk Products, Inc.	New York
7 and 8	E. L. Washburn & Co., Inc.	New Haven
9	Brewer and Company, Inc.	Worcester
10	Van Pelt and Brown, Inc.	Richmond
11	Lederle Laboratories	New York
12	C. V. Mosby Company	St. Louis
13 and 14	Professional Equipment Company	New Haven
15	D. G. Stoughton Co.	Hartford
16	White Laboratories, Inc.	Newark
17	Doho Chemical Corporation	New York
18 and 19	Surgeons & Physicians Supply Co.	Boston
20	E. F. Mahady Company	Boston
21	Reed and Carnrick	Jersey City
22	Philip Morris & Co., Ltd., Inc.	New York
23	Burroughs Wellcome & Co. (U. S. A.) Inc.	New York
24	Wm. P. Poythress and Co., Inc.	Richmond
25	Mead Johnson and Company	Evansville



155TH ANNUAL MEETING  
The Connecticut State Medical Society

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GENERAL PROGRAM

HAMDEN HIGH SCHOOL, APRIL 29 AND 30, 1947

Tuesday, April 29, 1947

COLE B. GIBSON, *President, presiding*

9:30 REGISTRATION

10:00 CALL TO ORDER

WELCOME—President of the New Haven County Medical Association

10:10 MOTION PICTURE

10:30 PHYSIOLOGIC AND ANTIBIOTIC THERAPY IN BRONCHIAL ASTHMA

Alvin L. Barach, *Presbyterian Hospital; Columbia University College of Physicians and Surgeons*

11:00 MANAGEMENT OF THE COMPLICATIONS OF DIABETES

Elaine P. Ralli, *Bellevue Hospital; New York University College of Medicine*

11:30 INTERMISSION AND MOTION PICTURE

12:00 LESIONS OF THE ANTRUM OF THE STOMACH

Richard Schatzki, *Massachusetts General Hospital; Harvard Medical School*

12:30 PRESENT STATUS OF THE MANAGEMENT OF THE RUPTURED INTERVERTEBRAL DISC

Jason Mixter, *Massachusetts General Hospital; Harvard Medical School*

1:00 LUNCHEON

2:15 SYMPOSIUM ON THE TREATMENT OF PERIPHERAL VASCULAR DISEASES

1. THE CONSERVATIVE TREATMENT OF PERIPHERAL ARTERIAL DISEASES

A. Wilbur Duryee, *New York Postgraduate Hospital; Columbia University College of Physicians and Surgeons*

2. THE CONSERVATIVE TREATMENT OF THROMBO-EMBOLIC DISEASES

Irving S. Wright, *New York Postgraduate Hospital; Columbia University College of Physicians and Surgeons*

3. THE SURGICAL TREATMENT OF VASCULAR DISEASES

John Homans, *Boston Dispensary; Tufts College Medical School*

A round table discussion, with Dr. Wright as chairman, will follow the formal presentations. The audience will be invited to participate and it is asked that questions on any phase of the subject be sent, at least two weeks in advance of the meeting, to Dr. William R. Resnik, 65 South Street, Stamford.

Wednesday, April 30, 1947

9:30 MOTION PICTURE

9:50 THE TREATMENT OF HYPERTENSION

1. END RESULTS AND INDICATIONS FOR THORACOLUMBAR SYMPATHECTOMY

William Hinton, *New York Postgraduate Hospital; Columbia University College of Physicians and Surgeons*

2. THE ROLE OF LOW SODIUM DIETS

George A. Perera, *Presbyterian Hospital; Columbia University College of Physicians and Surgeons*

10:30 THE DIAGNOSIS AND TREATMENT OF BRONCHIECTASIS

Herbert C. Maier, *Lenox Hill Hospital; Cornell University Medical College*

11:10 THE DIAGNOSIS AND TREATMENT OF CARCINOMA OF THE OESOPHAGUS

Richard H. Sweet, *Massachusetts General Hospital; Harvard Medical School*

11:40 INTERMISSION AND MOTION PICTURE

12:00 THE CLINICAL SIGNIFICANCE OF CHANGES IN SMALL INTESTINAL FUNCTION

Franz J. Ingelfinger, *Evans Memorial Hospital; Boston University School of Medicine*

12:30 THE MANAGEMENT OF ACUTE CORONARY THROMBOSIS AND ITS COMPLICATIONS

Samuel A. Levine, *Peter Bent Brigham Hospital; Harvard Medical School*

1:00 LUNCHEON

2:00 CONVOCATION OF THE SOCIETY

ADDRESS OF THE RETIRING PRESIDENT, COLE B. GIBSON

INTRODUCTION OF THE PRESIDENT-ELECT AND THE OFFICERS FOR 1947-1948

3:15 SYMPOSIUM ON PSYCHONEUROSIS

ARTHUR H. JACKSON, *presiding*

1. UNDERLYING PHYSIOLOGICAL AND PSYCHOLOGICAL BASES

Jacob E. Finesinger, *Massachusetts General Hospital; Harvard Medical School*

2. CLINICAL EVALUATION

Benjamin V. White, *Hartford Hospital*

3. REMEDIAL MEASURES

Carl A. L. Binger, *New York Hospital; Cornell University Medical College*

The Sections of the Society, which will meet on Tuesday and Wednesday afternoons, have not yet completed the arrangements for their programs. Full details of these meetings will be published in the April issue of the JOURNAL.



# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### Specialization and Sub-specialization

The growth of specialization is a phenomenon of such importance that it is pertinent to inquire where the process is leading. It is hard to avoid wondering whether clinicians are aware of the proportions to which sub-specialization has developed. Do physicians think this is desirable? In the beginning it was thought to be an advantage to have active clinicians who were qualified by study and experience to administer all that was known in the various clinical fields; specialists who could consult with family doctors and, when necessary, apply special technical skills. This, in general, was the role of a specialist forty years ago. Patients were referred by family doctors for help in diagnosis and treatment. If either required skill beyond the attainments of the family doctor, the patient remained in the specialist's care as long as necessary and then returned to his own physician.

This program not only made available the skills of specialists, when, in the judgment of the attendant they were needed, but it also left the general practitioner free to seek help without risking loss of contact with his patient. Beyond this the patient was not impelled by fear and worry to seek the services of specialists unnecessarily. Another great advantage was that of a continuing postgraduate course which the family doctor acquired through his contacts with the various specialists.

With the increase in the number and availability of specialists patients have been impressed by the

advantage of by-passing the family doctor and going directly to a specialist. This has placed on the patient the burden of first making his own diagnosis! Otherwise how could he tell which specialist to consult! Inevitably many incorrect diagnoses have resulted and, unfortunately, they have not invariably been corrected by the specialist thus consulted. This process is confusing for the patient and frustrating to the doctor who, through public pressure, often refers patients to specialists to such an extent that his function is largely confined to that of a clearing house.

A further step in the change in medical practice is the increase in sub-specialism. A surgeon now is a fracture surgeon, a chest surgeon, an ear, nose and throat specialist, a neuro-surgeon, an eye surgeon, a urological surgeon, a gynecologist, etc. Internal medicine which, by design or by accident, includes non surgical diseases of adults and excludes mental disorders, also is divided into branches dealing with the heart, diabetes, allergy, dermatology, arthritis, tuberculosis, gastro-enterology, etc.

Now the layman seeking a self selected specialist must first decide whether his disorder of nutrition is due to allergy, tuberculosis or diabetes. This, of course is an extreme example just as such a decision puts upon the patient an impossible burden. Through such an example it is easy to see that if clinicians continue to expand sub-specialization it will be necessary for patients to demand general practitioners for both economic and physical safety or facilities must be provided on an extensive basis for

group practice. At the moment the future seems to hold a vast increase in the number of clinicians devoting full time to a specialty within a specialty, accompanied by an increasing public demand for the services of specialists.

If this is a true impression of the outcome of the program of specialization it is important to inquire whether it is a desirable goal from the standpoint of either patients or doctors. Has the practice of medicine reached a point where it is necessary to establish the facilities both physical and personnel for group practice in accessible locations all over the country? It is implicit in this question that adequate groups include both specialists and sub-specialists.

Another aspect of sub-specialism concerns the co-ordination of the personnel. Even now there is evidence that this is seldom satisfactorily achieved, amongst the primary divisions. Obviously it will be more difficult as the subdivisions increase. Unless every patient always is seen by every member of a group there will arise the necessity for decisions outside of any particular specialist's province. The fracture surgeon confronted by a nutritional problem must decide whether or not to obtain the help of the metabolism expert. Or the division of arthritis may rely on the original survey and struggle through a period of uncertainty and disappointment because of an unrecognized intercurrent complication. These are practical questions and it is essential to meet them before the process of sub-specialization develops into an unwieldy monster incapable of management.

Lastly, there arises the question of the effects of concentrated training upon the specialists themselves. Just at the time when valiant voices are being raised in the interest of seeing the patient as a person, is it wise to promote sub-specialism, the presumed by-product of which may be to make it less possible to see the patient as a whole?

To raise these questions is not to imply that their answers are known. But it is to suggest the need for concern with the philosophy as well as with the technics of medical practice. Perhaps our readers would like to comment on this subject.

### Committee on Mental Institutions Reports

The special session of the General Assembly of May 1946 appointed a committee to study the State hospitals for the mentally ill and the training schools

for the mentally defective. This committee, headed by Senator Cornelius Mulvihill, has recently made its report to the 1947 General Assembly. It is a concise and carefully worded study of the problem which was to secure data concerning these institutions and to draft legislation designed to improve the State program in these fields. In all, the committee makes twenty-two recommendations, some of which require the enactment of legislation for their implementation. Among the recommendations which have a particular interest to physicians are:

I. That a temporary Commission be created with an appropriation to provide facilities for the care of the criminal insane and the insane with criminal tendencies in order that they may be removed from State hospitals for the mentally ill.

II. That the program of the Commission on the study of the chronically ill, aged, and infirm be facilitated by an appropriation to it by the 1947 General Assembly adequate to provide in the immediate future for facilities for their groups.

III. That the law permitting the admission of individuals by emergency commitment be revised to further safeguards in order to prevent the use of this procedure for the disposition of persons who are not mentally ill.

IV. That the social work program of the hospitals for the mentally ill be expanded.

IX. That the Merit System law be amended by eliminating both the provision that examinations for physicians of these hospitals and training schools shall be competitive and the provision that under any circumstances a period of residence be required.

X. That salaries paid to physicians, psychiatrists, nurses, attendants, psychiatric aides, and dietitians be made comparable to those paid for similar positions under the Veterans' Administration.

XIII. That the State prepare as soon as possible to build more and better living quarters for the professional staff at all institutions except Southbury.

### The Second Medical School

The reaction of the *Hartford Courant* to the recent special committee report to the Board of Trustees, University of Connecticut, appears elsewhere. It is a good reflection of the thinking of the report, especially in its analysis of our State's need for a second medical institution. One aspect of the report which is of significance is the recommendation by the committee to the Trustees to consider



the addition of a medically trained teacher to the University faculty. Such a person might be given a teaching position in a preclinical subject, serve as advisor in premedical sciences and as a coordinator for the teaching in the premedical field in the undergraduate college. Such a faculty member might also continue to study matters relating to the development of a medical school and keep the President and Board of Trustees informed in matters relating to medical education.

### Dr. G. Dick Read Speaks in New Haven

Dr. Grantly Dick Read of London was recently guest of the Department of Obstetrics and Gynecology, Yale School of Medicine. Dr. Read came to New Haven on January 22 and addressed 200 physicians and nurses in the Farnam Auditorium. For thirty-five years Dr. Read has been an advocate of drugless childbirth in normal labor and has written extensively on the subject. His visit to America is under the auspices of the Maternity Center Association of New York City and while here he will speak in various of the large eastern cities. Dr. Read's methods, which are stimulating interest among obstetricians in this country, consist essentially of a pains-taking program of antenatal care in which patients are informed of the fundamentals of pregnancy physiology with emphasis on the naturalness of normal labor. The advantages of the method, Dr. Read pointed out, are a shorter labor, less maternal injury, and less injury and shock to the infant. In specific cases when pain is experienced sedatives are given and nitrous oxide inhalations may also be used. Dr. Read, however, states that this is rarely necessary, particularly in those patients in whom normal labor is to be expected. Dr. Read also emphasized the importance of careful antenatal physical examination, including roentgen technics to rule out abnormalities.

### Dr. Miller Advocates Program For Community Cancer Control

The general practitioner can now have available in his own community the most recent scientific developments in the prevention, detection and treatment of cancer through a formula worked out by the American Cancer Society with the endorsement of the American Medical Association, James Raglan Miller, president-elect of the Connecticut State Medical Society, told an audience of physicians and

laymen at the Women's Hospital Annual Clinic Day observance in Detroit, Mich., Wednesday, January 15. Dr. Miller is a member of the Board of Trustees of the American Medical Association.

"Too many tears have been shed over the impending fate of the general practitioner," Dr. Miller said. "He is and always will be the cornerstone of medical care. We now have a formula whereby scientific services can be developed under the direction of his county medical society."

Dr. Miller said that the House of Delegates of the American Medical Association has approved the general policies of the American Cancer Society's program to set up local programs of cancer prevention, detection and treatment in cooperation with state and county medical societies.

A sound community program should include four essential points. They are: (1) an information service on cancer and control facilities available in the community; (2) a detection center where apparently well people may obtain general examination to disclose unsuspected disease; (3) a diagnostic clinic where persons having signs and symptoms of cancer may go for diagnosis; (4) a cancer clinic which provides staff and equipment for treatment.

"One of the great criticisms that the social planners have made is that physicians who are isolated by an all absorbing busy practice do not bring the best that modern medicine has to offer to the service of their patients," Dr. Miller said. "If these detection centers are properly developed under proper control, a physician may make use of them exactly as he does the laboratory for cultures, for the Wassermann test, and for x-ray examination of the lungs for tuberculosis.

"It is recognized that the scope and need for such a program can best be determined by local conditions and for this reason approval of the county medical society is required for all local service projects which are supported by funds of the American Cancer Society."

The following editorial of interest to our readers appeared on January 20, 1947, in the *Hartford Courant*.

### Another Medical School

It is good news to many persons in Connecticut that a subcommittee of trustees of the University of Connecticut takes a less dim view of the need for a second medical college in the State than did the

Hartford County Medical Association's committee a short time ago. The financial obstacles to such a venture being what they are, it may be assumed that no action will be taken immediately. But it is heartening to find that the trustees recognize increased facilities will be needed in the "near future," and that Hartford Hospital is also receptive to the idea.

The criticism had been made when the Medical Society opposed the proposal for a second school that the members seemed to consider the problem from the point of view of an adequate supply of doctors alone, rather than from that of the many young men in Connecticut now denied opportunity for a career in medicine through lack of sufficient facilities. The trustees' subcommittee, headed by Dr. Creighton Barker, secretary of the Connecticut State Medical Society, agrees that there is no shortage of doctors in Connecticut. With a host of physicians and surgeons now returned from the wars, that is undoubtedly true.

The fact remains that many young boys and girls of undeniable ability are now, through no fault of their own, kept from a career in this noblest of professions simply because Connecticut boasts but a single medical college, and that beset by too many applicants. Because of this unfortunate circumstance, the study finds, "Connecticut runs slightly below the national average among the States in proportion to its population who enter the study of medicine."

There is a need, the committee continues, for this State to realize its social obligation to contribute to the total number of persons educated in medicine for the benefit of the country as a whole. Surely Connecticut should bear its share of the total expense of manning a profession upon which the entire nation's health depends. Every year Connecticut faces a deficit of about fifty physicians, which it must offset from the national pool. As a State with a reputation for social consciousness, Connecticut should be helping to meet the nation's admitted need for doctors, instead of intensifying it. Another reason why Connecticut needs increased facilities for medical education, as the report observes, is the fact that the Yale Medical School quite properly considers itself a national institution, not one that can devote its efforts to students from Connecticut alone.

The committee estimates that a capital investment of \$2,500,000 and an annual cost of \$500,000 would be the minimum requirements for a medical school

in Hartford. Nothing on this scale can be attempted immediately. But a longer term project is possible and desirable. The trustees, after several months' study of the entire situation, find that the need does exist. The committee is to be congratulated for putting its recommendations on the basis of providing opportunity for Connecticut's youth, and of accepting this State's share of responsibility for the national well-being.

### Voluntary Insurance, New York State

*An editorial published in New York State Journal of Medicine*

What is the present status of the four existing prepaid medical care plans approved by the Medical Society of the State of New York? Certainly, progress has been made in the extension of coverage of individuals and groups during recent months.

Latest official figures show that during the first six months of 1946, enrollment in the four plans increased by over 155,000 members, exceeding the entire year of 1945 by over 28 per cent. From June 30, 1945 to June 30, 1946 enrollment increased by 230,671 members, or 119 per cent. During this period, United Medical Service, New York City, increased its membership by 168,000, or 158 per cent; Medical and Surgical Care, Incorporated, Utica, 25,026, or 68 per cent; Western New York Medical Plan, Incorporated, Buffalo, 32,651, or 67 per cent; and Central New York Medical Plan, Incorporated, Syracuse, 4,824, or 236 per cent. For the period from June 30, 1945 to January 1, 1946 the increase in members was 74,957 as compared to 155,714 from January 1, 1946 to June 30, 1946. At the present time the four plans have a membership of approximately 480,000 and at the current rate of increase there will be approximately 600,000 members as of December 31, 1946. This does not include any enrollment from the Rochester or Albany plans.

While the figures showing percentage of increase both for these plans and for United Medical Service as percentages are fairly satisfactory, they do not represent in our opinion all that could be accomplished and which must be accomplished if the voluntary plans are to compete in the public mind with schemes for compulsory health insurance under Federal control.

It is true that the rate of growth avoids the difficulty which would immediately arise with the adoption of compulsory insurance on a National scale, namely, the lack of facilities and of medical per-



nnel to implement it properly, but we doubt if the public is or has been made sufficiently aware of the vital importance of this defect inherent in the proposed National health insurance scheme.

To our mind this is an extremely important matter. In the event that the public, in spite of such informed advice and counsel as the medical profession can give it and must give it on this point, should be so foolish as to disregard expert advice and to decide upon the adoption of National compulsory health insurance, disregarding any other objection, the lack of sufficient doctors, nurses, and hospital facilities alone would be destructive of all the excellence which has been available under the present system of the slow growth of voluntary medical care insurance.

It is true that the coverage of such insurance is not universal, but in view of the practical points at issue, we think that good coverage within the means of accomplishing it, is better than an attempt at universal coverage which cannot be realized even with the enormous resources of the Federal government behind it.

We think that this is a practical matter if expressed in ordinary language the public can understand. We think it should be stressed and stressed again by every available means at our disposal. The public is, after all, practical and reasonable. It would, we think, support our contention on this ground alone. Every enterprise in this Nation started as a small business or manufacture or what have you. It grew with public acceptance of what it had to offer. If this offering was acceptable, the small enterprise grew larger and more efficient as the demand increased. We do not think the proposals for medical care can abandon practical considerations for theoretic substitutes proposed by political spenders and theorists whose ideas have been demonstrably cockeyed in whatever country they have been tried.

The progress of nationalization of the coal miners in England at the moment is running into the obstruction of reduced production of such an essential product because of the unwillingness of the now socialized miners to function as the socialists theoretically thought they would. Is there a lesson in this attitude of the English miners toward their socialized industry for what would probably happen to the product of medical care in America under a nationalized compulsory sickness insurance scheme?

## Are You a Fellow A.M.A.? Better Sign Up

The American Medical Association is going to celebrate its centennial in Atlantic City, June 9-13, 1947. Elaborate plans are being made for this celebration.

Only Fellows and invited guests are eligible to attend. Membership in your state society is the primary qualification for Fellowship in the A.M.A. Fellowship dues and subscription to the *Journal of the A.M.A.* are both included in one annual payment of \$8 which is the cost of the *Journal* to subscribers who are not fellows.

Applications for Fellowship may be obtained from the Society office.

## Appoint New Director for Associated Medical Care Plans

Associated Medical Care Plans, recently organized coordinating agency for prepaid medical care plans in the United States sponsored by the American Medical Association, has announced the appointment of Frank E. Smith, PH.D., as its director. He has already taken over his duties at the headquarters of the American Medical Association, 535 N. Dearborn Street, Chicago.

The Associated Medical Care Plans was incorporated recently under the laws of the State of Illinois. The new corporation is a national non profit organization which will include all state and local non profit medical care plans that comply with the minimum standards for medical service approved by the Council on Medical Service of the American Medical Association.

Mr. Smith did his undergraduate work at the University of Southern California, spent two years at Yale and two more years at Northwestern University where he received his PH.D. in Philosophy in 1939.

Previous to his appointment as director of Associated Medical Care Plans, Mr. Smith spent two years in the Los Angeles office of the California Physicians Service as director of Public and Professional Relations.

## THE PRESIDENT'S PAGE

AT THE semi-annual meeting of the House of Delegates in December the President was empowered to appoint a Committee to Study the Organization and Objectives of the Society. This action resulted from a recommendation contained in the report of the Executive Secretary and from a resolution introduced by the delegates from New Haven County. The Executive Secretary likened our Society to an outmoded house and he suggested that we survey this edifice "to see how it can be improved and to seek a plan for future remodeling and addition."

Clearly it can be agreed that such a survey is indicated and that it should prove fruitful. The construction, the machinery and the production of our Society require detailed evaluation both from the standpoint of today's efficiency and of tomorrow's progress. We need to know if we do as well as we should with what we have. We need to know if our machinery is geared and timed to meet the demands of modern medicine. We need to know if we are laboring in non productive fields, and if we are allowing to lie fallow certain ground of potentially great fertility.

For its beginning activity certain items for study have been suggested to the Committee. These include under the heading of *Organization*—

(1) A complete survey of the Council: Whether it is properly representative; whether it should be enlarged and how; whether all members should vote; whether it should continue to act as the Nominating Committee of the Society; whether tenure on the Council should be restricted; whether its powers should be more or less limited.

(2) An evaluation of the financial operations of the Society: Whether income is adequate; classification of the treasurer's functions; define policy relative to expenses of officials and employees; investigate federal tax position; what support should be given to committee activities.

(3) Study of committee operations and responsibilities.

Under the heading of *Objectives* a number of subjects deserve consideration, such as, the educational purposes of the Society and methods for promoting activity in this field; the relation of the Society to public and private agencies; the policy of the Society in legislative matters; improvement of interest in the County Associations and a closer relationship between these and the State Society; and continued expansion in the field of public relations.

Undoubtedly other phases of the activities of the Society will be scrutinized, for there is no limitation of scope or time for this Committee to which falls a task of such importance. This job will require many hours of study. It will call for judgment and vision. The men who compose the Committee will need to sacrifice their time and energy, but knowing the true devotion that each has for medicine and the Society, we may confidently expect results for which we shall all be grateful.

Cole B. Gibson, M.D.



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## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

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### COUNCIL MEETING

The regular monthly meeting of the Council was called to order by the Chairman, Dr. Murdock, at 4:30 P. M., Tuesday, February 4, 1947, at the offices of the Society. There were present: Drs. Murdock, Moore, LaMoore, Howard, Thoms, Gildersleeve, Phillips, Gibson, Speight, Miller, Campbell, Barker, Miss Mooney. ABSENT: Drs. Weld, Mullins, Weed.

#### NATIONAL PHYSICIANS COMMITTEE

It was voted to establish a state committee to cooperate with the National Physicians Committee including one member from each county association in Connecticut.

#### SEMI-ANNUAL CONFERENCE OF COUNTY PRESIDENTS AND SECRETARIES

It was voted to hold the Semi-Annual Conference of Presidents and Secretaries in New Haven on March 20. The Conference will convene late in the afternoon for a discussion of administration in county associations; collection of dues and membership recruitment. The members of the Conference will be the guests of the Council for dinner and an after-dinner speaker will discuss developments of prepaid medical service.

#### COMMITTEE TO STUDY THE ORGANIZATION AND OBJECTIVES OF THE SOCIETY

Dr. Gibson, the president of the Society, informed the Council that he had appointed the Committee to Study the Organization and Objectives of the Society as authorized by the House of Delegates at the Semi-Annual Meeting in December 1946. The Committee will consist of the elected councilors from each of the eight component county associations and one other representative of each county association as follows: Fairfield, Oliver L. Stringfield; Hartford, Arthur B. Landry; Litchfield, Thomas J. Danaher; Middlesex, Frank H. Couch; New Haven, Courtney C. Bishop; New London, Charles C. Barnum; Tolland, William Schneider; Windham, William M. Shepard. The president invited the members of the Committee for an organization meeting and dinner at Graduate's Club on February 19.

#### NEW COMMITTEE TO STUDY WORKMAN'S COMPENSA- TION LAWS

In compliance with a vote taken by the House of Delegates at the December meeting, the Council has appointed a new Committee to Study Compensation Laws consisting of Chairman, Addison H. Bissell, Stamford; Ettore F. Carniglia, Hartford; Clarence H. Cole, Waterbury; John F. Kilgus, Litchfield, Thomas Soltz, New London.

#### RESIGNATION OF DR. SULLIVAN

The Council received the resignation of Dr. Daniel Sullivan as a member of the Board of Trustees of the Society's Building Fund and gave consideration to the appointment of a successor. During the discussion of this appointment, the Secretary gave an informal report concerning the status of the Building Fund. The total amount pledged is \$65,089; cash received and on deposit exclusive of the amount paid for the building site is now approximately \$40,000. The number of contributors to date is 956 or 42.7 per cent of the membership of the Society. The recent personal solicitations have been quite productive in Fairfield, Hartford and Windham Counties.

#### STATE COMMISSION ON THE CARE OF THE CHRONICALLY ILL AND INFIRM

The Council considered and made recommendation to the Governor for appointment of another physician as a member of the State Commission on the Care of the Chronically Ill, Aged and Infirm.

#### NOMINATIONS

Additional nominations for officers and members of the committees for the year 1947-48 were made.

The next regular meeting of the Council will be at the Society's office on March 7.

## Memorial Gift to Building Fund

A gift of one thousand dollars in memory of Dr. Amos J. Givens, founder and director of Stamford Hall, and two succeeding directors, Dr. Frank W. Robertson and Dr. Francis M. Shockley, was recently presented to the trustees of the Society's Building Fund.

The gift was presented by Mr. Paul W. McFadden, manager of the hospital, to Dr. Oliver L. Stringfield, Stamford representative of the Building Fund.

It is the third memorial gift to be received by the trustees, and plans are now being considered to create appropriate memorials in the new Medical Society building.



AMOS J. GIVENS, M.D.

The gift in memory of the Stamford Hall founder and directors recalls a long and significant development in the treatment of mental illnesses. The institution was established by Dr. Givens in 1892, in response to a need which he foresaw for a sanitarium in the vicinity of New York City. He came to Stamford with the experience of a number of years as a staff physician of the state hospitals in Minnesota, Massachusetts, and New York.

The sanitarium soon became one of the most successful ventures of its type, outgrew its original facilities, and steadily expanded until it became a relatively self-sufficient village in itself. The thousands of patients treated here included prominent people from every state and from foreign countries.

The confidence of physicians in Dr. Givens's skill and knowledge was evidenced in the large number of patients committed to his care and in frequent requests for consultations. Those who enjoyed his acquaintance often expressed surprise at the unusual energy and ability which he displayed throughout his quarter century of medical practice in Stamford.

But medicine displayed only one facet of his wide range of competence. In 1916 he was elected president of the Fidelity Title and Trust Company, Stamford, of which he had been vice-president for several years. To friends who considered this abrupt change from medicine to banking as a quite uncertain move, he explained that he found his best recreation in a change of work. With this will to pursue new endeavors, he became in a few years a competent and widely recognized banking authority. He was also attracted to the writing of scientific essays, of which he produced an impressive number.

In 1913 Wesleyan University conferred upon him an honorary degree in law, and for a number of years thereafter he served as one of the directors of that institution. In the summer of 1919 he became seriously ill and died in Stamford on July 7 of that year.

Following the death of the founder, one of his life-long friends and medical associates, Dr. Frank W. Robertson, then a well known practicing psychiatrist in New York City, became president and medical director of Stamford Hall. In addition to directing the affairs of the sanitarium, Dr. Robertson devoted considerable time to the study of legal-medical problems incident to child adoption. In 1930 he was engaged by the Honorable Homer S. Cummings to assist in a study of conditions at the Connecticut State Prison in Wethersfield.

Upon the retirement of Dr. Robertson in 1935, the directorship of Stamford Hall was placed in the hands of Dr. Francis M. Shockley, who had been engaged as assistant director of the institution in 1934. As an army medical officer, Dr. Shockley had served in the first World War as a division surgeon in France, in the rank of lieutenant colonel. Because of a serious illness, he resigned as director of the sanitarium on July 1, 1943 and died at the Veteran's



Hospital, Bronx, New York, April 22, 1944.

Dr. Robertson, for several years following his retirement, served as a consultant to the medical director of the New York Telephone Company and is a consultant in psychiatry for two New York City banks. A lingering illness resulted in his death on August 28, 1938 at his home in Old Greenwich.

### Meetings Held During February

Tuesday, February 4, 4:40 P. M.

Council of the Society

Monday, February 17, 5:50 P. M.

Board of Trustees of the Building Fund

Tuesday, February 18, 2:00 P. M.

Committee on Prepaid Medical Service, Hunt Memorial, Hartford

Wednesday, February 19, 11:00 A. M.

Executive Meeting, Connecticut Medical Examining Board, State Capitol, Hartford

Thursday, February 20, 7:30 P. M.

Committee on Tumor Study, Waterbury Hospital

Wednesday, February 26, 7:00 P. M.

Committee on Industrial Health

Thursday, February 27, 4:30 P. M.

Committee on Military History

### Meetings Scheduled for March

Sunday, March 2

Committee on Public Policy and Legislation

Friday, March 7

Council of the Society

Thursday, March 20, 4:00 P. M.

Conference of Presidents and Secretaries of the County Medical Associations with the Council of the Society

### Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

DePasquale, F. L., Hartford (A)

Durkee, Ralph E., Jr. Hartford (USPH)

Feeney, Thomas, Hartford (N)

Morris, Felix R., Bridgeport (A)

Mulville, Maurice F. (N)

Davis, James S., South Norwalk

Reported discharged from service in error

Costanzo, Ralph E., Stamford

Deceased while still in service.

## THESE GAVE

### CONTRIBUTORS TO THE BUILDING FUND — JANUARY 10 TO FEBRUARY 10

#### HARTFORD COUNTY

Allen, G. F., Hartford  
Beardsley, L. G., Newington  
Bobrow, Aaron, Hartford  
Brackett, A. S., Bristol  
Clark, B. B., New Britain  
Farquhar, L. R., Avon  
Glass, W. H., Hartford  
Goodrich, C. A., Hartford  
Irving, G. J., Hartford  
Karpe, Richard, West Hartford  
Lankin, J. J., Hartford  
Levin, A. E., Hartford  
Messina, M. C., Bay Pines, Fla.

#### HARTFORD COUNTY—Continued

Millen, S. R., Rocky Hill  
Paolillo, C. G., New Britain  
Purinton, C. O., New Hartford  
Radom, M. M., Hartford  
Salvin, B. L., Hartford  
Smith, W. B., Wethersfield  
Whipple, B. N., Bristol  
Wiepert, W. M., Avon

#### NEW HAVEN COUNTY

Campbell, Sherburne, Wallingford

#### NEW LONDON COUNTY

Henkle, R. T., New London

#### FAIRFIELD COUNTY

Abrahamson, R. H., Stamford  
Bannon, F. M., Stamford  
Beck, S. H., Bridgeport  
Brodsky, M.E., Bridgeport  
Bullen, B. W., Greenwich  
(non member)  
Dorian, R. H., Stamford  
Kaplan, Leon, Bridgeport  
Pellens, Mildred, Bridgeport  
Read, F. A., Greenwich

#### WINDHAM COUNTY

Girouard, J. A., Willimantic  
Raymer, J. G., Willimantic

### Appointed Radiologist

The appointment of Dr. Charles Verstandig, of New Haven, as director of radiology at the Connecticut State Hospital in Middletown, was recently announced by Dr. Edgar C. Yerbury, superintendent of the institution.

Since the new position will not require his full time, Dr. Verstandig plans to continue his private practice in New Haven. He is a graduate of Tufts Medical College, 1932, and served his internship at St. Raphael's Hospital, New Haven, later becoming assistant resident in surgery at St. Joseph's Hospital, Paterson, N. J. Following five years as radiologist at the University of Tennessee, he served in a similar capacity for one year at the Wright Clinic, Houston, Texas. He recently completed five years service in the Army.

Dr. Verstandig is a diplomate of the American Board of Radiology, a member of the American College of Radiology, the American College of Physicians, the Radiological Society of North America, and the New England Roentgenological Society.

### Appointed to National Committee on Rural Medical Service

Dr. Norman H. Gardner, of East Hampton, has been appointed a member of the National Committee on Rural Medical Service of the American Medical Association.

The appointment was received by Dr. Gardner while attending the annual conference of the committee, held in Chicago February 6 and 7. He is chairman of the State Medical Society's rural health committee, which is now conducting a state-wide survey aimed toward improving health facilities and services in smaller towns and villages. Other members of the committee include Dr. Gert S. Guder-natch of Sharon; Dr. David H. Bates of Putnam; and Dr. William H. Upson of Suffield.

### Psychiatric Home for Child Study to be Proposed

Construction of a Psychiatric Study Home for Children by the state will be recommended to the current session of the General Assembly, according to the State Health Department. The proposed study home would be placed under the administration of the health department and would be integrated with

the children's psychiatric clinics which the department conducts. The recommendation for the study home has been made by a committee which former Governor Baldwin appointed some time ago to make a survey of the need for such a home.

The department also anticipates creation of a central registry for psychiatric cases in the state to obtain statistical information about the incidence of various types of mental conditions in the state, and so that individual names may be cleared through for a variety of purposes, such as selective service, finding of lost persons, or selection of cases for research purposes.

Also the department hopes to add a well qualified psychiatric social worker to the staff of its bureau of hygiene for assignment to its bureau of public health nursing as a consultant.

The Bureau of Hygiene has started a training program in which psychiatrists are given training in the field of child psychology. Fellows in child psychiatry are assigned to the bureau which has been approved by the Division of Community Clinics of the National Committee for Mental Hygiene. The bureau hopes in the future to accept interns in psychology for training purposes.

### Appointed to State Board

Dr. Charles T. Bingham of Hartford was recently appointed to the Board of Trustees of the State Fund for Inebriates by Governor James L. McConaughy.

Dr. Bingham will complete the unexpired term of Dr. Thomas P. Murdock of Meriden, whose resignation became effective January 11. The term ends July 1, 1950.

### Putnam Hospital Loses Prominent Surgeon

Joseph Antonio LaPalme, M.D., of Putnam died suddenly of coronary thrombosis at the home of his father in Webster, Massachusetts, on January 21, 1947. His death came as a shock to his many friends as he had been in apparent good health and was active in his professional work up to that time. Tony LaPalme was but 46 years old and held the position of surgeon on the staff of the Day Kimball Hospital in Putnam where he will be greatly missed. Full military honors were accorded the late U. S. Navy Commander at the funeral by members of the Veterans of Foreign Wars and of the American Legion.



## Our Friends in the South

Stopping off at Florence, South Carolina, to pay my respects to one of Medicine's leaders, Julian P. Price, pediatrician, secretary of the South Carolina Medical Association and editor of its *Journal*, I was privileged to be a guest at the annual meeting of the Marlborough County Medical Society held at Bennettsville. My host on that occasion has been largely responsible for the South Carolina Association's leadership in organized medicine. With its Ten Point Program it has stimulated its membership to an active interest in prepaid plans for hospital and medical care, in better health legislation for that State, and in a higher type of medical practice among its members. Dr. Price's renown as a presiding officer has become nationwide since the 1946 Conference of Secretaries and Editors in Chicago, in fact, he has become almost one of those indispensables in arranging and carrying through many of the conferences which meet at the home of the American Medical Association many times throughout the year.

This particular county meeting was a gala occasion and, according to custom, drew physicians from as far west as Greenville, South Carolina, and from such cities as Charlotte in the neighboring State of North Carolina. As a guest from the cold and far distant North I was introduced and had the opportunity to pay tribute to South Carolina as the birthplace of Cole Blease Gibson, the illustrious president of the Connecticut State Medical Society. Following a sumptuous dinner the gathering was addressed in true Southern oratorical style by the president of the South Carolina Medical Association, Dr. James McLeod, who, during the last gubernatorial campaign, had been an unsuccessful candidate for that office. Dr. McLeod is one of South Carolina's leading surgeons and the head of the McLeod Infirmary, founded by his father at Florence. In the scientific program which followed the members and guests to the number of approximately one hundred were presented with a case report of acute myeloid leukemia associated with erythroblastosis. This was ably discussed by an internist and by a pathologist, both from Charlotte, North Carolina. The program ended with movies showing the latest developments in surgery of the heart.

Over in Sarasota, Florida, I found Joseph H. Hal-

ton, a perennial summer visitor in Hartford, carrying on in his private hospital in his usual efficient manner. Dr. Halton, during his forty years in Sarasota, has watched that city grow from a small fishing hamlet comprising a handful of houses to its present size as one of the leading winter resorts on the west coast of Florida. The fact is, Dr. Halton has been a part of Sarasota during these four decades. The first mayor of the city, chairman of the Board of Education, leader in all the developments for civic improvement, Dr. Halton has a life story to tell which is loaded with thrills. He can entertain his listener with tales of how he started in practicing medicine on horseback, carrying his instruments and pills and powders in his saddlebags, traveling for miles around to combat hookworm, rattlesnake bite and tropical fevers. Performing all his own surgery, he was often honored with visits from such leaders as Fred Albee, Charles Mayo and George Crile.

Dr. Halton's treks north each summer for postgraduate training present a program of study which none but a virile student of medicine could carry on. One summer in Baltimore with Howard Kelly and T. S. Cullen. The next summer to Toronto to the laboratory of John Caven. Two years later to New York Postgraduate Hospital to study the diseases of children and infant feeding under Drs. Dennett and Pease. Another summer to New York City for obstetrics at the Lying-In Hospital under James Marhau and to the Postgraduate Hospital again for physical diagnosis, infant feeding and genito-urinary work. And so on down through the years to New York City, to Washington, D. C., to Chicago, to Guy's Hospital and the London General in England, to St. Petrier and Hotel Due in Paris, to Philadelphia, Boston, Saranac Lake, St. Louis, Buffalo and Hartford for instruction under such top notchers as John Erdman, Fred Albee, William Halsted, Elliott Joslin, Lester Unger, George Crile, Chevalier Jackson, John Deaver, Howard Taylor, Frank Lahey, John Moorhead, Paul White, Alfred Rowley and James R. Miller. Dr. Halton's life has been a fascinating one, filled with the satisfaction which comes from the realization that he has brought to his section of Florida's West Coast the best that medicine has had to offer. This was reflected in his smile and hearty handshake as I bid adieu to the Southland.

Peripateticus

## *Doctor---*

*YOUR PATIENTS WILL BE INTERESTED IN THIS!*

### **STAND UP AND SAY "AH"**

Michael Wright in *Better Homes & Gardens*

This is how it is in Britain. The doctor got back to his office just at two o'clock. "How many?" he said to his nurse.

"Forty."

Casually, he put on his white jacket and poked his head into the waiting room where the 40 patients sat. "Will those of you troubled with headache please stand," he said.

Six stood. The doctor took identical printed prescriptions out of his desk and handed one to each of the six and dismissed them.

Then he said, "Will those of you troubled with a cough please stand." Another group got up, and again he handed them printed prescriptions and dismissed them.

The others he took one by one into his private office for a few minutes. Two hours later the office was empty, the 40 patients gone. This was an average of three minutes to a patient.

And that, Dr. Edward H. Ochsner of Chicago testified at the recent Wagner-Murray-Dingell bill hearings in Washington, is how it is with socialized medicine in Britain.

In Germany, where they also had a compulsory system, some doctors did even better—30 to 40 patients in one hour.

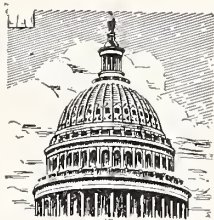
This is how most doctors believe it will be here in America if our own womb-to-tomb compulsory health scheme becomes law.

*Reprinted by permission of Better Homes & Gardens Magazine*

**If Free Enterprise in American Medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. He must learn the dangers which threaten society, and each day, each member must do some educational work with his patients.**



COMMITTEE ON PUBLIC POLICY AND LEGISLATION  
*Fairfield County*, Charles H. Sprague, Bridgeport  
*Hartford County*, Benjamin B. Robbins, Bristol  
*Litchfield County*, W. Bradford Walker, Cornwall  
*Middlesex County*, Frank H. Couch, Cromwell  
*New London County*, Edmund L. Douglass, *Chairman*  
Groton  
*New Haven County*, Charles T. Flynn, New Haven  
*Tolland County*, John E. Flaherty, Rockville  
*Windham County*, Brae Rafferty, Willimantic



PUBLIC  
AFFAIRS

NEWS FROM WASHINGTON

New Health Bills in Congress

The first week of the 80th Congress saw two important health bills introduced. The first, the Fulbright-Taft bill (S140), is to create a cabinet post for a Department of Health, Education, and Security. We are informed by the United Public Health League that this bill is expected to receive a build-up from the wife of the editor and publisher of the *Washington Post*, that this is one of Mrs. Meyer's very favored projects. Marjorie Shearon, research analyst for the Conference of the Majority in the U. S. Senate, warns us that this cabinet post will probably go to a welfare official, combining the social work viewpoint with a bias in favor of national social insurance. This would make out of the Department of Health, Welfare, and Education a glorified Federal Security Agency, the worst possible set-up for health and medical activities. The other bill, HR605, was introduced by Dr. Miller of Nebraska and is to establish a Department of National Health. This bill is the same as HR1391 which Dr. Miller introduced in the 79th Congress.

Subsequent to the first week there has been introduced the Taft-Ball-Smith bill (S2143) which proposes an independent health agency with an administrator reporting to the President. Such an agency would derive its authority from Congress, have its own funds, and not be subordinate to a lay agency. The administrator would be a doctor of medicine and surgery, but would not have Cabinet status. It would seem to those who are familiar with Congressional minds to be thoroughly unrealistic to hold out for a Department of Health at this time. Federal health activities, funds, and personnel are not presently at a level to warrant Departmental status. This is believed to be the first step toward seeking a separate health agency later.

Three bills for the study of cancer have been introduced. S93 by Mr. Pepper of Florida and HR780 by Mrs. Douglas of California would authorize and request the President to undertake to mobilize at some convenient place or places in the United States an adequate number of the world's outstanding experts and coordinate and utilize their services in a supreme endeavor to discover means of preventing and curing cancer. HR977 introduced by Mr. Stevenson of Wisconsin would provide for the mobilization of the scientific resources and knowledge of the United States for the purpose of seeking the causes and cure of cancer, poliomyelitis, and certain other degenerative diseases of mankind.

Health Insurance Law Seen in G. O. P.  
Drive in Congress

From the United Public Health League comes the news that Senator Smith, Republican, of New Jersey, has predicted a Republican drive to enact a national health insurance law early in the new Congress.

Senator Smith said the plan would feature voluntary participation, with each State left to work out its own insurance program for hospital and medical care. Federal aid from a \$200,000,000 fund would be made available, principally to help low income groups.

Noting that the proposal differs sharply from the administration backed compulsory insurance plan which failed in the last session, Senator Smith told a reporter the Republican bill probably will draw opposition of "those who want over-all Federal control."

"We want to give the greatest measure of freedom to the States in setting up their health insurance plans," the Senator declared. "We want to get away from the idea that some bureaucrat here can say to

the State, 'Follow my instructions or you don't get any money'."

Hence, Senator Smith said, the measure will provide for a council to which a State can appeal any dispute over the proposed grants-in-aid. These would be on the basis of \$2 in Federal funds for every \$1 put up by the State.

Senator Smith is a member of the committee assigned to report on a health program for the Senate Republican membership.

### Taft's Radio Talk Heartening to U. S. Doctors, Journal Says

Senator Robert A. Taft's recent radio address in which he assailed the Wagner-Murray-Dingell bill because it "attempts to impose a complete system of compulsory sickness insurance on all people in the United States" carried a heartening message for the American physician, says the January 18 issue of *The Journal of the American Medical Association*.

*The Journal's* editorial follows in full:

On January 3 Hon. Robert A. Taft, senator from Ohio, spoke over the facilities of the National Broadcasting Company on "A Republican Program." In the course of the address, which appeared later as "Extension of Remarks" in the Congressional Record, Senator Taft referred briefly to the place of health in the program. He said:

"So, also in the health field we are proposing a program to assist the states and local governments in making their treatment of the indigent and medically indigent more systematic and complete. We should encourage the formation of plans for voluntary health insurance to be available to those who wish to take it out. On the other hand, we strenuously oppose the Wagner-Murray-Dingell bill, which attempts to impose a complete system of compulsory sickness insurance on all the people in the United States. That plan would tax the people to raise four or five billion dollars a year to pour into Washington to be used by a federal bureau to pay all the doctors to give free medical care to all the people of the United States. It is not only a socialization of medicine but it is the federalization of medicine. No other measure before the American people proposes such a tremendous increase in the right of the federal government to interfere with the daily lives of the people. It flies in the face of every principle for which the Republican Party stands."

The language is direct; the principles are sound; the message is heartening!

In his message to the Congress on the state of the nation, President Truman indicated in vague generalities his belief in the desirability of better availability for medical care. Then on January 10 he sent to the Congress his budget and his message, in which he was somewhat more explicit. He said:

"Recent legislation for hospital construction, for increased activities in mental health and for expanded maternal and child health services are substantial achievements toward improving the substandard health level of a large part of the population. But the major problem of financing health care still persists. Therefore I again urge the Congress to enact a health insurance program which will make adequate medical care available to every one and provide protection against the economic hardships of sickness. Such a program should be almost entirely self financing through payroll contributions."

Last year the President carefully explained several times that he did not believe this program to be "socialized medicine." That excursion into semantics was of little avail in convincing the American people. Now taxes are referred to pleasantly as "payroll contributions." Moreover, the medical care of all the people by a bureaucracy is characterized as "health insurance." Isn't it really "federalized medicine"?

On January 10 also Senator J. William Fullbright, democrat of Arkansas, for himself and Senator Robert A. Taft, republican of Ohio, introduced a proposal for a new Department of Health, Education and Security in the Cabinet. This proposal would put all health, social security and educational functions of the government under supervision of a new Cabinet officer. Already conferences are being developed in which representatives of various national organizations concerned with these functions in our civilization will meet to interchange views on the principles which should prevail in the establishment of such an agency and on the qualifications of the personnel selected to administer the services. The proposal would seem to be a much needed step toward assembling the medical functions of the federal government in a single agency with direct access to the Cabinet. This is a principle for which the American Medical Association has contended since its organization one hundred years ago. The fact that President Truman suggested its adoption in his message this year and that the proposal comes under



joint sponsorship of both major political parties would seem to indicate likelihood of early enactment.

In his message President Truman referred also to the desirability of legislation in behalf of the establishment of a National Science Foundation. At a recent meeting of the American Association for the Advancement of Science, leaders in many fields of science, including medicine, proposed early conferences with a view to improving on the text of the Kilgore-Magnuson bill, which passed the Senate last year. On this subject Senator Taft said recently:

"We are also proposing a measure to set up a permanent scientific foundation to promote research in many fields. Our measure creates a scientific council of fifty leading scientists to select the director and determine the scope of the work. This is a substantial modification of the Kilgore-Magnuson bill of the last session, which authorized the President to appoint a director with fifteen bureau chiefs and an elaborate organization, directly subject to political pressure."

Here again there would appear to be a desire to give government back to the people.

In concluding his message Senator Taft said:

"In every field they will invite counsel from the best minds, initiate studies and recommend measures for future enactment."

Physicians who have fought unceasingly in behalf of the fundamental principles of freedom in the intimate affairs of our lives and in the further advancement of medical science, which has reached, under our system of government, the highest level ever attained anywhere in the world, will read in these words a promise of success for our objectives. Physicians know the importance of unimpeded respiration for health and vitality. Apparently we may—at least for a time—breathe easier.

### Proposes State Health Plan

Appointment of a 12-member commission to study the need for state controlled medical care is proposed in a bill recently introduced in the General Assembly by Senator Albert L. Coles, of Bridgeport, who represents the Twenty-Second District.

Entered on the Senate calendar as Bill No. 291, the legislation would empower the Governor to name a commission to represent labor, management, industry, agriculture, medical schools, the medical profession, hospitals, and the general public.

The bill grants the commission power to subpoena

witnesses and conduct hearings concerning the need for low cost medical, surgical, and hospital care to be provided through a system of health insurance administered by the state. Following hearings, the commission would make its recommendations to the Governor.

### State of Connecticut Undertakes Treatment of Alcoholics

The State of Connecticut is now in the business of curing people of alcoholism, according to a recent Associated Press story.

The former Yale School Plan Clinics have been taken over by the Commission on Alcoholism, created by the 1945 general assembly along with the state fund for inebriates. The commission was created to plan for outpatient and inpatient care, the treatment and detention of patients with alcoholism.

Under the Connecticut plan, the staff is enlarged by the addition of a full time clinical psychiatrist, Dr. Theodore P. Sohler, who has been at New Haven Hospital Yale School of Medicine as physician-in-charge of the psychiatric outpatient clinic.

Executive director of the Commission is Dr. Dudley Porter Miller of New Haven, who plans to set up in addition to the Hartford clinic and the one at Yale additional facilities as soon as space, equipment and personnel can be secured in the major population centers in the state.

"We need as many as we can establish," Dr. Miller said. "Hand in hand with this proposed outline of plans, the commission envisages the establishment of a commitment center and one or more convalescent centers. In the latter facility, patients would be cared for on an inpatient basis."

Dr. Miller said he hoped to establish relations with private, municipal and state social agencies, hospitals and courts, whereby the work of the commission and the agencies may be of mutual benefit in caring for alcoholics.

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### Dr. Castle to Speak at Yale

Dr. William D. Castle, chairman of the Department of Medicine, Harvard Medical School, will speak in the auditorium of the Yale Law School on Thursday, March 6, 1947 at 8:00 P. M. His subject will be, "Blood Destruction of the Hemolytic Anemias." Dr. Castle comes to New Haven under the auspices of the Alpha Kappa Kappa medical fraternity. The lecture is open to all interested.

## CONNECTICUT CANCER SOCIETY

### WANTED: LOCAL LEADERSHIP

EDWIN R. MEISS, *Waterbury*

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The Author, *Managing Director, Connecticut Cancer Society*

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THE third annual national Cancer Campaign will take place during the month of April when the American Cancer Society and its state divisions will seek 12 million dollars to carry on their program of research, education and service.

Because of public response and the expanded program made possible by the funds, the problem of local medical leadership has become increasingly a matter of concern to the Society.

In two short years, the collections in Connecticut have increased from less than \$9,000 in 1944 to more than \$290,000 in 1946. The 1947 goal has been set at \$275,000 and an organization to secure the success of this drive is already well under way.

As a rule, physicians have not been asked to undertake the chore of raising funds. Connecticut has led the country each year in per capita contributions. To achieve this, business and civic leaders in every community of the state have joined with women volunteers to build a fund that would really begin to make headway against cancer.

There are notable exceptions. A few physicians acted as campaign chairmen and were among the most successful, but on the whole the committees did not consider it fair to impose upon physicians who were already carrying a great professional load and ask them to raise funds.

What the lay volunteers in the cancer cause have looked to physicians for, however, is their cooperation, advice and supervision in the year round cancer control program which these new funds have made possible in each community.

The State Society has been most fortunate in having interested, progressive physicians directing its program. These men believe in education as a means for controlling cancer. They believe that research can be empowered for greater accomplishment and, until the problem is solved, they believe

in providing increasing comfort and care to those who are victims of cancer.

The physicians on the Connecticut Cancer Society's state committees are representative of all the agencies which cooperate in the fight against cancer and their help has been indispensable to the program of the past few years.

At the local level this is also true of a few communities, but in too many districts the lay volunteers of the Cancer Society look in vain for spirited and active cooperation among the physicians in their midst. Medical men sometimes criticize the intrusion of lay people in their field, when in reality they may be encouraging such intrusion by failure to participate and provide guidance.

Of the money raised by the Connecticut Cancer Society, 40 per cent goes to the national program with its coordinated research directed by the National Research Council. Sixty per cent remains within the state. During the past year, more than \$100,000 has been allocated for grants requested by local committees to carry out community projects. Funds were supplied to Visiting Nurse Associations, for medical social workers, and for tumor clinic personnel. Each community was entitled to a Field Army Fund for service to patients. Two important clinical research programs were supported in Connecticut and funds were made available for detection clinics in three large cities.

This is only a partial list. All projects were carefully weighed by the Medical Advisory Committee nominated by the Committee on Tumor Study of the State Medical Society.

But the work of the Connecticut Cancer Society is essentially conceived in terms of community programs. Cancer funds provide opportunity for local accomplishment which would seem worth the attention of physicians despite the pressure of other professional duties.

At meetings of local committees the lay chairman not infrequently regrets that "Dr. Smith could not make it," and "Dr. Jones said he would be along if



he could get away." The meeting then takes place with the lay group forced to rely on its own judgments for decisions which should have the benefit of a physician's experience.

In some cases, lay workers find not just professional apathy but even discouragement. Fortunately public interest and progress against cancer, as shown by the tapering off of the rising death rate in Connecticut, have changed the attitude of some who used to frown on cancer control activities.

The pressure for action against cancer is rapidly increasing. The public is awakened. Belief in research is greater than at any previous time.

Locally, money is available to achieve early diagnosis and treatment, to improve facilities and to carry out projects for cancer control. The band of men and women who are devoted to this cause want medical leadership. In them the medical profession has a group who believe as they do in the free enterprise system. They deserve the encouragement and active cooperation of the local physician. It is sound professional service. It is good humanitarianism. It is the better part of wisdom.

### Campaign Notes

Waterbury Junior Chamber of Commerce has agreed to adopt the Cancer Drive as its project and give all-out support to Raymond Fanning, district campaign chairman. A Junior Chamber Committee composed of Thomas Leonard, Charles Barbour, and Sidney Posin is already working to put Waterbury over the top in 1947.

Six Hartford banks have agreed to send out more than 41,000 campaign folders in their April statements. Why not ask for similar help of the banks in your community? Hartford Gas Company is repeating its 1946 service of distributing 35,000 folders with bills.

Master of the Connecticut State Grange, Harry L. Page of Guilford, has offered us his cooperation in the coming campaign. There are 158 Granges in Connecticut with 27,000 members. Several local masters of the Grange have already been helpful in obtaining campaign chairmen, and we hope all our chairmen will seek the support of their local Grange members.

Publisher Harry F. Morse (*Connecticut Circle*), Connecticut State campaign chairman, will join State

chairman and national leaders in St. Louis, February 7, for a campaign pow-wow.

The National Society has asked Connecticut to set its goal for 1947 at the same figure as in 1946—\$277,440. Of the amount raised, 60 per cent will again remain within the state, 40 per cent going to American Cancer Society's national program of education and research.

A grant of \$1,000 was made by the Society at the request of the Connecticut Branch of the American Academy of Pediatrics to help complete its study of child health services in the state by collecting data not heretofore available on the qualifications of pediatricians and medical facilities for the care of children. The study will provide a key to local improvement. Cancer, it was pointed out, is the sixth cause of death among children from 4 to 14 years.

Maurice R. Moore, M.D., of Norwich has been appointed district president.

### First Cancer Consultative Clinic

Heralded by front page headlines, the first Cancer Consultative Clinic, sponsored by the Connecticut Cancer Society, opened in Hartford January 28, with five physicians in attendance.

At last we can satisfy requests for an examination for cancer. The clinic is open Tuesday mornings from 9 to 12 at McCook Memorial Hospital, 2 Holcomb Avenue, Hartford, and will serve persons from all over the state. Have your patient telephone Mrs. Helen Russell at Hartford, 2-4864, for an appointment.

### Oklahoma Advertisises

The Oklahoma State Medical Association sponsored a series of advertisements in newspapers throughout the state. The program extended from October 27 to November 1. At the completion of the series, reprints were made to be displayed in drug stores, hotel lobbies, schools, industries and businesses. Each ad features a particular idea, such as "taking a pill isn't a short cut to health." It then went on to explain or picture the idea in more detail. The whole program was designed to tell medicine's story in a manner easily understandable by the public.

## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*  
 EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven  
 JOSEPH N. D'ESOP, New Haven

#### Veterans Administration Activities Reviewed for Year by Manager Wood

Expansion of its medical facilities, extension and improvement of its contact service, and the securing and training of employees, highlighted Veterans Administration activities in Connecticut during 1946, Harry T. Wood, manager of the Hartford Regional Office, stated recently.

"One of the greatest problems facing us a year ago," Wood said, "was the lack of trained employees to handle increasing work loads resulting from the rapid demobilization of armed forces. In addition we had to establish contact offices throughout the state, in order to bring VA services to the veteran's home community.

"We faced 1946 with 400 employees, the nucleus of an organization which would have to serve upwards of 250,000 veterans. We had to grow fast, and as a result, experienced a few growing pains. But we have now reached that stage in development where, because of increased skills on the job, we can face the New Year with confidence in our ability to serve efficiently and accurately the veterans and their dependents in this state."

Mr. Wood said that the VA is now an organization of more than 1,050 full time employees, and that it has established full time offices in 18 communities and that 30 other Connecticut communities are served on an itinerant basis.

Last year, according to the Regional Office manager, saw the development of the complete outpatient clinic at 95 Pearl Street. "During 1946 our medical division gave more than 70,000 medical examinations and more than 36,000 treatments," Mr. Wood said.

He added that the volume of business during the year had been large, with more than 75,000 veterans receiving certificates of eligibility for jobs and more than 74,000 having filed varying kinds of claims.

"The amount of work done by each division is

evident from these statistics as of December 31, 1946," he said.

"A total of 32,241 veterans of World War I and II are receiving pensions or compensation; close to 32,000 are attending schools or colleges or taking on the job training in this state; and 6,511 have obtained GI loans, totaling \$41,833,271.

"Thousands of veterans are interviewed each month by our contact representatives," Mr. Wood continued, "and more than 3,500 are paying their National Service Life Insurance premiums each month at the collection units in Hartford and New Haven.

"More than 500 veterans a month are making application for domiciliary or hospital care, and more than 1,000 claims are adjudicated every month.

"During December," he added, "subsistence allowance checks, totalling \$2,207,247 were mailed to veterans in educational institutions or taking on-the-job training in the state. Pension and compensation checks mailed to Connecticut veterans during December totalled \$1,450,822.

"We greet the New Year with confidence that as each day passes there will be an improvement in our service to veterans."

#### VA Furloughs Hospital Patients to Alleviate Shortage of Beds

Authorization has been granted to VA hospital managers to furlough patients whose treatment can be completed adequately out of hospitals, and thus make more beds available to veterans awaiting hospitalization. This move to alleviate the current shortage of VA hospital beds was announced by Dr. Winthrop Adams, of Boston, director of Medical Services for the Veterans Administration in New England.

"The new program divides the patients whose hospitalization may be shortened into service-connected and non service-connected cases," explained



## SPECIAL ATTENTION

### VETERANS ADMINISTRATION

95 Pearl Street  
Hartford 4, Connecticut

January 31, 1947

Creighton Barker, M.D.  
Connecticut State Medical Society  
258 Church Street  
New Haven 10, Conn.

Dear Dr. Barker:

From time to time medical officers in the field receive questions concerning the propriety of treating eligible veterans for conditions contributing, and medically related, to the specific service connected condition for which authorization for treatment has been granted.

Under present law, outpatient treatment of veterans is limited to service connected conditions, except under certain specific circumstances. However, the fulfillment of our professional responsibility to eligible veterans necessarily involves medically adjunct, related and contributing conditions, to the extent possible under existing law.

Pharmacists must accept prescriptions for veterans which carry proper VA authorization from physicians or dentists. If any medication is later determined to be altogether inappropriate for the condition authorized for treatment, or not reasonably attributable to such service connected condition, it is within the authority of finance officers to refuse payment for such pharmaceutical service. This imposes a serious and unfair penalty upon pharmacists acting in good faith. It is obvious that the participating pharmacist is without means to evaluate the extent of authority of the physician or dentist in terms of the nature of the condition properly under treatment. It is, therefore, requested that all participating physicians and dentists be informed that they must be meticulous in ordering only such medication as can be considered reasonably appropriate for such patient in the light of the authorized service connected disability and contributing or related conditions.

It is requested that the contents of this letter be brought to the attention of all practicing physicians in the State of Connecticut through the medium of the CONNECTICUT STATE MEDICAL JOURNAL.

Very truly yours,

s/ F. J. RYAN  
F. J. RYAN, M.D.  
Acting Chief Medical Officer

Dr. Adams. "Service-connected patients whose disabilities have improved sufficiently to be treated elsewhere will be discharged from VA hospitals, and will receive outpatient treatment in VA hospital clinics or in regional and subregional offices. Or they may be treated on a fee basis as circumstances warrant. Transportation for this treatment may be furnished at government expense.

"The non service-connected cases which can be given final treatment on an outpatient basis, will be granted leaves of absence from VA hospitals. However, they still will be carried on hospital rolls as patients, reporting instead to VA hospital clinics or regional and subregional offices. The government will not pay transportation costs or other expenses for this treatment, which will be provided only at VA installations," he said.

Dr. Adams emphasized that the program will apply only to those patients whose actual period of hospitalization may be shortened by this method, without prolonging treatment or impeding recovery.

In New England on December 1 patients awaiting admission to VA hospitals numbered 564, of whom only six were in the service-connected category. At present it is estimated that about 17 per cent of hospitalized veterans are service-connected cases, the balance being non service-connected.

### Newington VA Hospital Adds To Its Staff

Appointment of 18 medical consultants, 13 attending and 21 resident physicians to the staff of the Veterans Administration Hospital in Newington has been announced by Lewis G. Beardsley, M.D., manager. The consultants and attending physicians, all well known Connecticut specialists, were selected by the Dean's committee of Yale University School of Medicine, Francis G. Blake, M.D., chairman. The resident physicians were also selected and approved by this same committee for training in the Newington Hospital. They are graduates of approved medical schools, have completed their internships, and desire to fulfill requirements for specialty board certification.

### Veterans Administration Adopts Artificial Eye Developed by Army

The Army's plastic artificial eye has been used by more than 7,500 former soldiers during the past three years and has been adopted by Veterans Administration in furnishing ocular prosthesis to

patients, the War Department announced recently.

Developed first in 1943 by a former major in the Army Dental Corps while stationed in England, this type of acrylic eye has practically replaced glass eyes which were used almost exclusively before World War II. The Army Medical Department developed this eye after the war broke out, when both civilian and military supplies of artificial eyes were depleted due to high breakage and inability to replenish supplies. Glass eyes then used in the United States were largely German made.

As early as 1943, the Army made plans to discard the easily breakable, inferior, custom-made glass eye when Major (then Lieutenant) Stanley F. Erpf of San Francisco, California, assigned to the job by Col. Derrick T. Vail, consultant in ophthalmology in ETO, successfully demonstrated the artificial eye made of water-clear plastic and individually fitted and colored. In January 1944 the first training center for ophthalmoprosthetists was organized at the 30th General Hospital, England. Forty American dental officers and 10 British dental officers attended.

Dr. Robert E. Stewart, chief of the Ophthalmoprosthetic and Restoration Division of The Prosthetic Appliances Service of Veterans Administration, said today that all 15 technicians making artificial plastic eyes for VA are Army trained. They were dental officers and technicians especially trained in this work during the war.

"The Army developed artificial eye has proven superior to any other type of ocular prosthesis available today," Dr. Stewart declared. "Of about 500 World War II Veterans who have applied to Veterans Administration for ocular prosthesis aid, none had any serious complaint about the acrylic eye. They wanted lost eyes replaced, socket corrections or needed refitting because of other operations."

Dr. Stewart said the Army developed eyes were never broken when dropped nor has the coloring in the eyes deteriorated. He explained that some eyes had become roughened due to hard usage, but this is easily remedied.

Veterans Administration scientists have changed the Army's painting technique slightly in making the eyes, but that is the only difference in government issue and VA artificial eyes. Some scientific circles were of the opinion that the nylon threads used in veining the eyes would deteriorate and lose their original color. Dr. Stewart reported that no such deterioration has been noted by VA specialists.



Another principal feature of the durability of Army founded artificial eyes is that there is no evidence of etching or corrosion even in eyes worn by patients over a three year period.

Credit for the development of the Army's acrylic eye is accorded by Major General Norman T. Kirk, The Surgeon General, to Major Erpf, who initially introduced the eye which has undergone few modifications. He returned to the United States from England in June of 1944 to collaborate with Major Milton S. Wirtz, Latimer, Iowa, and Major Victor H. Dietz, Chicago, Illinois, ocular prosthetic specialists in perfecting the acrylic eye, at Valley Forge General Hospital, Phoenixville, Pennsylvania. A school was started here to train technicians who were then sent to other general hospitals.

By that time, 13 general hospitals in the European Theater of Operations possessed personnel and facilities for the fabrication of acrylic eyes. In October 1944, 12 general hospitals in the United States were similarly equipped. The Army continued to enlarge upon its artificial eye program until in October 1945 30 Medical Department installations have inserted more than 7,500 plastic artificial eyes. When V-J Day came there were acrylic eye teams in Hawaii and the Philippines.

General Kirk said that Army patients equipped with this prosthesis were issued new eyes whenever medically necessary. No requests were received for replacement of the eye because of structural or material weakness. Veterans Administration reports the same findings among veterans wearing this acrylic eye.

### Veterans Administration

The number of veterans hospitalized by Veterans Administration reached a new all-time high on January 22.

VA reported that a total of 119,845 veterans were receiving treatment in VA hospitals and homes and in non VA hospitals under contract to VA on that date.

VA's load of veteran patients has been increasing steadily. A year ago 92,276 veterans were hospitalized by VA and six months ago, 99,509.

Of the nearly 120,000 patients under VA care on January 22, a total of 90,470 were in VA hospitals; 15,298, in VA homes, and 14,077, in non VA hospitals.

While the number of veterans hospitalized has been increasing, the number awaiting hospitalization has been declining. On January 1 only 22,385 veterans with non service-connected disabilities were awaiting VA hospitalization, the smallest number since March 1946.

The drop was attributed to an increase in the number of beds available in VA hospitals and homes and to a more rapid turnover of patients because of improved medical treatment.

The number of applications on file for hospital and domiciliary care also dropped during December to 63,387, a new low since June 1946. The decrease probably was caused by veterans delaying their applications for treatment until after the Christmas holidays, rather than to a drop in the number in need of medical attention.

Veterans with service-connected ailments are given top priority for VA hospitalization, but veterans with non service-connected disorders are hospitalized only when beds are available and if they say they cannot afford treatment in other institutions.

### Veneral Control Council Established

The War Department announced recently the establishment of a Venereal Disease Control Council for the purpose of insuring that all possible control measures are employed and to reduce the rate of venereal disease in the Army.

The Council will meet each month to consider venereal disease problems as they effect service personnel, develop standard educational and control measures, and review control procedures adopted in the field. In addition, it is authorized to take immediate corrective action when reports indicate the existence of unsatisfactory conditions that are beyond the control of the local or Army commander and to establish policy for reduction and control of venereal disease based on appropriate research studies, surveys and field experience. It will also coordinate and assist the Joint Army and Navy Disciplinary Control Board on disciplinary problems related to venereal disease control.

Major General Willard S. Paul, director of Personnel and Administration, has been designated as chairman of the Council. Other members already appointed are Major General Norman T. Kirk, The Surgeon General; Major General Floyd L. Parks, chief, Public Relations Division; Chaplain (Major

General) Luther D. Miller, chief of Chaplains; Brigadier General Russel B. Reynolds, chief, Special Services Division; Brigadier General Blackshear, M. Bryan, The Provost Marshal General; and the Recorder, Lieutenant Colonel John J. Easton, Personnel and Administration Division.

Representatives of the Secretary of War, Army Ground Forces and Army Air Forces will be named to the Council early in January.

In another way the Army was continuing its drive against venereal disease as the first post war classes in venereology at a civilian institution opened in December 1946 at the University of Pennsylvania, Philadelphia, with sixteen selected Army Medical Department officers enrolled.

Major General Norman T. Kirk, The Surgeon General, said that the officers will study for two months in the Institute For The Study of Venereal Disease at the University before returning to their stations in Army General Hospitals and Air Forces. Another class is scheduled to open in January at the University of Southern California, Los Angeles.

General Kirk explained that such courses had become necessary so that medical officers versed in venereology could replace those venereal disease specialists being separated from the Service. Rapidly changing treatment policies also require that a trained venereologist administer the Army's program of treatment for venereal disease.

"This abbreviated course will not give us specialists in venereal disease management," General Kirk declared, "but it will be a step in the right direction. We must have Regular Army and Category I medical officers to replace those specialists in venereology who are being separated from the Service and to assure uninterrupted work in venereal disease control. Expert civilian consultants in this field are also available to the Army."

Dr. John H. Stokes, director of the Institute For The Study of Venereal Disease and Professor of Dermatology-Syphilology in the Graduate School of Medicine, University of Pennsylvania, will conduct the two-month course. Dr. Stokes is a medical consultant to the Secretary of War through The Surgeon General.

### Women War Veterans

Veterans Administration has reported that 1,339 women war veterans were patients in VA hospitals or in other hospitals under contract to VA on

November 30, 1946.

The potential load of women war veterans is estimated at 350,000.

Women veterans are entitled to the same medical care as male veterans. In addition, they may receive hospitalization for non service-connected disabilities in civil hospitals when government facilities are not available.

This additional benefit is given women veterans as a result of an executive order issued in 1933. At that time, only a few women veterans of World War I were eligible for VA medical care and it was deemed more economical to authorize treatment and hospitalization for them from private physicians and in private hospitals than to construct special facilities in existing VA hospitals.

Of the women patients on the rolls last November 30, a total of 923 were in VA hospitals and 416 in non VA hospitals. In addition to those hospitalized, another 212 were patients in VA homes.

Of the women war veterans in hospitals on November 30, a total of 890 were veterans of World War II. The remaining 449 were veterans of the first World War. Only nine of the 212 in VA homes were veterans of World War II.

VA has 14,989 women veterans on its pension and compensation rolls at present. Of this number, 13,533 are service-connected cases and the remaining 1,456 are non service-connected.

Of the total number of service-connected cases, 10,675 are veterans of World War II and the remaining 2,858 are veterans of World War I.

Of the non service-connected cases, 1,452 are veterans of World War I and only four (4) veterans of the second World War. Only in cases of permanent, total disability are pensions allowed for non service-connected disabilities.

### Veterans Advised to Pay Insurance With Bonds

Veterans who wish to assign their "terminal leave" bonds to Veterans Administration as payments on their National Service Life or U. S. Government Life Insurance should get the required forms from their nearest VA office where they may also get up to date information regarding GI insurance.

Although VA does not issue "terminal leave" bonds, it is authorized to accept them in connection



with Government life insurance payments. The bonds may be used (1) to pay premiums already in force; (2) to purchase new insurance; (3) to reinstate lapsed insurance; (4) to pay the amount required when converting term insurance to permanent forms; and (5) to repay policy loans made prior to July 31, 1946.

When a bond is issued for insurance premium payments it must be assigned in its entirety. Any balance over the amount necessary to make the desired payment will be credited to the veteran's account and will be used for paying future premiums. However, the veteran may specifically request that the balance be held for him until the bond's maturity date.

### Dr. Herman G. Weiskotten Elected Chairman of A.M.A. Council

Herman G. Weiskotten, M.D., dean of Syracuse University College of Medicine, Syracuse, N. Y., has been elected chairman of the Council on Medical Education and Hospitals of the American Medical Association.

Dr. Weiskotten, who is also professor of pathology at Syracuse University, has served the council several times during the last 20 years. He directed and conducted the survey of the medical schools of the country 10 years ago, and reported the findings in the volume, "Medical Education in the United States, 1934-1937." Although Dr. Weiskotten's major interest has long been in medical education, he has taken an active part in public health work, serving as commissioner of health of Syracuse and as a member of the New York State Public Health Council. He is an author of "Medical Care of the Discharged Hospital Patient."

From its origin in 1905, the council has had only two chairmen previously—the late Arthur Dean Bevan, M.D., professor of surgery at Rush Medical College, Chicago, and Ray Lyman Wilbur, M.D., chancellor emeritus of Stanford University, Palo Alto, California.

Dr. Bevan led the council through the revolutionary period of early medical school inspections and the emergence of medical education in this country to a high level of quality. During Dr. Wilbur's tenure, the medical schools were further strengthened, the hospital program of the council greatly expanded

and the many problems of wartime medical education were met.

Secretary Victor Johnson, M.D., Chicago, says that "the council now faces great responsibilities in the reconversion of medical education, the improvement of hospital internships and residencies, the large task of meeting the educational desires of physician veterans and other equally important problems."

### Plain Label Regulation of Drugs

One year ago FDA Regulation No. 2.106 simplified the sale of medicine for consumers and druggists by requiring:

(1) *All medicines that are "safe and efficacious" in the hands of the lay public must bear adequate directions for use.* In general, these include "all the ordinary" laxatives, iron compounds, cough and cold preparations, pain relievers (or analgesics), vitamins, tonics, pile ointments, antacids and antiseptics. Products bearing labels which give directions for use may be purchased over the counter by anyone, with or without a prescription.

(2) *All other medicines must carry the legend, "Caution to be dispensed only by or on the prescription of a physician."* These include more potent preparations such as penicillin, the sulfa drugs, barbiturates, heart stimulants, arsenicals, antitoxins, and many others. Medicines bearing the Rx label cannot be sold legally except on prescription.

### American Society for the Study of Sterility

The third annual convention of the American Society for the Study of Sterility will be held at the Hotel Strand, Atlantic City, New Jersey, on June 7-8, 1947. The general theme of the meetings will be that of attempting to disseminate to the physician treating marital infertility an overall picture of the latest advances in reproduction. The convention will include original papers, round table discussions, scientific exhibits and personal demonstrations.

In essence, this will be a valuable postgraduate course in the subject of sterility and infertility. Registration for the sessions is open to members of the medical and allied professions. Additional information may be obtained from the secretary, Dr. John O. Haman, 490 Post Street, San Francisco 2, California.

## Have You Answered Questionnaire on Medical Care of Civilians?

Parallel with the advance of scientific warfare there has been a rapid advance in scientific medicine in the Twentieth Century. The huge strides made in our ability to destroy life and health in the recent war, however, have left many problems which remain to be solved. One of the most critical problems, as recognized by the House of Delegates of the American Medical Association in its December meeting, is that of providing care for the civilian population in the event of another national emergency.

The medical profession is wisely assuming its obligation to the American people to be prepared with facts and recommendations for any such future emergency. As a first step in this preparation, 5,000 questionnaires have gone out to a list of physicians, selected at random, who passed the recent war years in civilian practice.

On the basis of the answers to these questionnaires, sent out by the Committee on National Emergency Service of the A.M.A., it is hoped that facts may be determined as to how the civilian population was served in World War II. The questionnaires also provide an opportunity for those who were responsible for civilian care in those years, to indicate what changes should be made in the mobilization of medical service in future emergencies.

Five thousand questionnaires represents a very small percentage of the total number of physicians who remained in civilian practice. Dr. Edward L. Bortz, Philadelphia, chairman of the Committee on National Emergency Service, has appealed to every physician receiving the civilian questionnaire to respond promptly. The accuracy of the facts obtained and the soundness of the conclusions made by the study will be determined to a great degree by the cooperation which those receiving the questionnaire give the committee.

The committee received excellent cooperation from the 50,616 former medical officers who were mailed questionnaires last December on their experience in military service. These are now being analyzed and studied. The facts obtained will be used as a basis for recommendations to be made by the Committee in June to the House of Delegates.

With the cooperation of the 5,000 physicians who are now receiving questionnaires on their civilian experience, the committee will be able to complete

the total study of how the medical profession can best serve our population, civilian and military, in the event of a future national emergency.

Every physician receiving one of these questionnaires has a professional and humanitarian duty to perform in completing it and returning it promptly. It is preferred that each sign his name, but if anyone wishes to remain anonymous, he may do so. The important thing is to get as broad a representation of facts, experiences, and opinions as possible.

## 80 Voluntary Health Plans in 33 States Cover Four Million

"Driving to complete the voluntary health insurance program for the care of the American people is the big job facing local, state and national medical organizations today," according to Thomas A. Hendricks, secretary of the Council on Medical Service of the American Medical Association. "More than 80 plans sponsored by medical societies in 33 states covering 4,000,000 persons are now in operation and the task has just begun.

"The pioneering state of voluntary health insurance is nearing completion and, nationally, we are rapidly entering the development stage. Only two states do not have a plan operating or in the process of formation. Plans for a prepayment program are now being made in 13 states and the District of Columbia. Growth of the plans now in operation has been rapid, the overall expansion within the last six months being as phenomenal a production figure as has appeared in modern insurance records.

"The enrollment in prepayment plans has accelerated slowly. This was partly due to the difficulties developed in the early experimentation stages through which such plans had to pass, and partly to hesitancy on the part of doctors to plunge into an untested field of endeavor. As the number of plans has increased, so too has the acceleration in enrollment. During 1945 the overall increase was 114 per cent. For the first six months of 1946 the enrollment increase was approximately 40 per cent, bringing the total to nearly the 4,000,000 mark. Indications are that enrollment will reach 5,000,000 by early 1947.

"One of the objectives of the Council on Medical Service is to present the facts in regard to advantages and disadvantages of the various plans, keep records up to date on all new developments in the medical care field, conciliate differences of opinion as to the



various forms of insurance—in short, view the entire question impartially and objectively, in order to do everything possible to encourage the whole-hearted acceptance by every state society of a practical, workable plan.

“The whole insurance program is still experimental. No one knows the complete answer. Hence, the Council hopes to encourage all types of plans that meet the minimum requirements set by the Council to maintain the standard of medical service for the protection of the public.

“The Council is now set up to do the job of (1) encouraging development of new plans; (2) keeping the profession informed as to developments; and (3) helping to increase the enrollment of plans already established.

“A prepayment division of the Council has been created with George Cooley, assistant secretary of the Council, keeping in contact with medical society-sponsored plans; Howard Brower, maintaining contact with private insurance groups; and L. S. Kleinschmidt, concentrating his efforts on encouraging rural enrollment and maintaining contact with the newly created consumer cooperative movement.

“Prepayment plans have progressed rapidly in the cities, but development in the rural areas has been slow, although several plans have been making notable advancements along this line.

“Jay Ketchum, Lansing, executive vice-president of Michigan Medical Service, is acting as consultant for the Council.

“Within the past few months private insurance carriers are showing an intense interest in medical and surgical care coverage and, as a result, there have been many conferences both formal and informal. A joint conference was held with representatives of large insurance associations in Chicago in September, with Dr. E. J. McCormick, of Toledo, chairman of the Council, presiding.

“One of the most important developments has been the creation of Associated Medical Care Plans, with Dr. H. L. Schriver, of Cincinnati, Ohio, as president; William M. Bowman, San Francisco, vice-president; Jay Ketchum, secretary; and Dr. Norman Scott, Newark, N. J., treasurer. In a sense this is a trade organization of plans. It can be of great service in developing reciprocity, details of selling, cooperative actions and procedures. Frank Smith, who has served with the California Physicians' Service, San Francisco, as director of public relations, recently has been appointed A.M.C.P. director. Although

A.M.C.P. will be housed with the Council and its work integrated with the work of the Council and in accord with the policies of the Council, it is a legal entity separate and distinct from the Council. The board of trustees has allotted through the Council sufficient funds to this organization to get started.

“The Council is also aided by Frank Dickinson, PH.D., director of the Bureau of Medical Economic Research of the American Medical Association, and T. V. McDavitt of the A.M.A. staff has served as the legal advisor of A.M.C.P.”

## 52 Plans Granted Seal of Acceptance by Council on Medical Service

The Council on Medical Service of the American Medical Association announces that a total of 52 prepayment medical care plans have been granted the “Seal of Acceptance.”

The most recent plans which were granted the right to use the seal are the Louisiana Physicians Service, Inc., New Orleans, New Hampshire-Vermont Physicians Service, Concord, N. H., and the 23 member bureaus of the Washington State Medical Bureau.

Louisiana Physicians Service, Inc., is a statewide plan sponsored by the Louisiana State Medical Society with offices in the Tulane Building, New Orleans. Frank Lais, Jr., is the executive director.

New Hampshire-Vermont Physicians Service is the result of the merging of New Hampshire Physicians Service, Concord, N. H., with Vermont Physicians Service, Rutland, Vt. The executive offices are located at Concord and the executive director is R. S. Spaulding. This is the first plan sponsored by the medical profession which covers the population of the two states under a single administrative office.

The standards under which a plan is granted the Seal of Acceptance require that it must first have the approval of the state medical society or, if local, it must be approved by the local medical society in the area in which it operates. The members of the medical profession must assume responsibility for the medical services included in the benefits. The plan should have no regulation which restricts free choice of a qualified doctor of medicine who is practicing in the locality covered by the plan and who is willing to give service under the conditions established. The method of giving the service must retain the personal, confidential relationship between

the patient and the physician. These and other qualifications must be met by plans seeking the right to use the Council's seal.

Of special interest regarding prepayment medical care plans on a nationwide basis is the fact that those with a large number of employees have expressed a desire to deal exclusively with plans which merit the Council's Seal of Acceptance.

### Plan for Uniform Intern Placement

A new agreement for internship placement was formulated at a meeting of the Committee on Internships and Residencies of the Association of American Medical Colleges, at Edgewater Park, Miss., on October 28, 1946. Representatives of the Council on Medical Education and Hospitals of the American Medical Association, the American Hospital Association and the Catholic Hospital Association, participated. Although it was not possible for the American Protestant Hospital Association to send a delegate, the plan as subsequently adopted was approved by the trustees of this Association. Following unanimous approval at the executive session of the Association of American Medical Colleges, the Council on Professional Practice of the American Hospital Association, the Council on Medical Education and Hospitals of the American Medical Association, and the Catholic Hospital Association, took confirmatory action.

#### DETAILS OF PLAN

1. That letters of recommendation by faculty members as a hospital requirement should be eliminated, all information about applicants being centralized in the deans' offices and credentials sent out from there.<sup>1</sup>

2. That the hospitals be requested to eliminate statement from intern application blank that the student will agree to accept if appointed.

3. Date for filing applications and release of credentials by the medical schools set at October 15, 1947.<sup>2</sup>

4. Appointment date by hospitals, not before November 15, 1947.<sup>2</sup>

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1. This action was taken in an effort to relieve overburdened faculty members of the task of writing an increasing number of letters of recommendation to support internship applications. Also, it was hoped that the information from the faculty might be assembled in the Dean's office and then incorporated in one letter of recommendation. This should simplify the work of the hospitals in reviewing the records and recommendations on each case.

5. No specific waiting period following announcement of appointments. Hospitals will be requested to notify all applicants of acceptance, alternate position, or rejection (with the understanding that notification of rejection may be made by the hospital at any time).<sup>3</sup>

6. Notification is to be sent to the hospitals that it is anticipated that dates for filing release of information and appointment will be moved farther into the senior year in 1949.<sup>4</sup>

### Dr. Victor Johnson To Take Up Mayo Foundation Post April 1

Victor Johnson, M.D., who has been secretary of the Council on Medical Education and Hospitals of the American Medical Association, Chicago, since 1943, announced recently his appointment to the post of director of the Mayo Foundation for Medical Education and Research at Rochester, Minn. Dr. Johnson, who will also serve as professor of physiology at the University of Minnesota, will succeed Donald Balfour, M.D., when he becomes director emeritus of the Mayo Foundation in October 1947.

Dr. Johnson will take up his new duties April 1.

He was graduated from the University of Chicago, where he received his M.D. degree and his Ph.D. degree in physiology. Dr. Johnson has been a member of the University of Chicago faculty since 1929 and was Dean of Students in Biology and Medicine from 1940 until 1943. At that time he was appointed secretary of the Council on Medical Education and Hospitals of the A.M.A. In accepting the Mayo Foundation post, Dr. Johnson has resigned his professional lectureship in physiology at the University of Chicago and his position with the A.M.A. He will continue, however, to serve as a member of the Council on Medical Education and Hospitals of the A.M.A., having recently been elected to succeed Ray Lyman Wilbur, M.D., Palo Alto, California, as a member of the Council.

Dr. Johnson is a member of the advisory committee of the Surgeon General of the U. S. Public Health Service in the administration of the recently passed Hospital Survey and Construction Act, of the Citizens Federal Advisory Committee of the U. S. Office of Education, of the Civilian Production

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2. These dates are for internships beginning July 1, 1948.

3. Rejection notices may be sent as soon as decision is made, any time before appointment date, or as soon as possible after that date.

4. For internships beginning in 1949.



Board and of the Advisory Board on Health Services of the American Red Cross. He is a member of numerous scientific and educational organizations including the American Physiological Society, the American Association for the Advancement of Science and the American College of Physicians. He has written many papers on the blood and circulation, as well as articles on medical education and the advanced hospital training of physicians, and several books.

## Anthallan and Hyperesthetic Rhinitis

(Reprinted from *Journal A.M.A.*)

Recently newspaper and radio publicity has been given to a report\* of use in the treatment of 42 patients with "hyperesthetic rhinitis" of a new drug, "Anthallan." Anthallan is a benzofuran derivative; other information on its chemical or pharmacologic properties has apparently not been published; it is said to be marketed by the Medico Chemical Corporation of New York City.

The author of the report claims to have coined the term "hyperesthetic rhinitis" to cover cases of rhinitis in which there is an element of "hypersensitivity of the nasal mucosa," symptoms of excessive nasal discharge, excess sneezing and nasal obstruction. It is difficult to perceive wherein these cases differ from those which have heretofore been grouped under the term "vasomotor rhinitis" or "hay fever." Certainly it is unwise to introduce a new term into a field already distinguished by a multitude of ill defined conditions to which a confusing variety of names has been assigned.

Appraisal of the effectiveness of anthallan from the treatment of the 42 patients who form the clinical material of this report is difficult. The results are obscured by a complicated system of assigning numerical values to the symptoms of the patient, then averaging these and comparing these averages with those derived from similar numerical values assigned at the end of treatment. The differences are expressed in percentage of improvement. The elements which were assessed by this statistical process were the patient's statement about his symptoms, the color of the mucous membrane, the amount of breathing space and the amount of visible

secretion in the nose. In a masterly understatement the author admits that "numerical evaluation does not always express the whole clinical impression of the patient's condition. . . ." Therefore he assigns similar numerical values to a diagnostic criterion termed a "medical estimate."

This attempt to measure accurately factors which are not measurable is absurd. The result of the statistical manipulations described is to make impossible any scientific appraisal of the effects, if any, produced by the drug. The statement is made that "every change in the nasal manifestations observed during the period of treatment with anthallan can be attributed to the influence of the drug." The only justification for this statement appears to be that "the anthallan treatment period was considerably shorter than the period during which the manifestations had existed."

The laboratory studies reported included observations on red blood cell counts, white blood cell and differential counts, blood glucose, blood nonprotein nitrogen, electrocardiogram and nasal smear eosinophils. Significant changes in these well recognized factors were not observed.

Notably lacking in this report are parallel studies on control patients or, in fact, any controls whatsoever. There does not seem to be any basis in the author's results for the recent newspaper and radio publicity given anthallan as a new "cure" for hay fever. Until more convincing and scientifically controlled investigations are reported, the decision regarding the efficacy and value of anthallan must be deferred.



\*Ghiselin, A. D., Jr.: The Treatment of Seasonal and Nonseasonal Hyperesthetic Rhinitis with Anthallan, *Bull. New York Acad. Med.* 22:320 (June) 1946.

## COUNCIL OF THE NEW ENGLAND STATE MEDICAL SOCIETIES

A meeting of the Council of the New England State Medical Societies was held at the Copley Plaza Hotel in Boston on Wednesday, January 15. The meeting was called to order at 4:00 P. M. by President Carleton R. Metcalf, M.D., who reported that the secretaries of the New England State Boards of Medical Examiners were meeting at the same time with the Council at its request.

The following members of the Council were in attendance at the meeting:

<i>Connecticut:</i>	<i>Rhode Island:</i>
C. Frederick Yeager, M.D.	Herman C. Pitts, M.D.
Joseph H. Howard, M.D.	Mr. John E. Farrell
<i>Maine:</i>	<i>Massachusetts:</i>
Frederick R. Carter, M.D.	Allen G. Rice, M.D.
Adam P. Leighton, M.D.	Michael A. Tighe, M.D.
Mr. W. Mayo Payson,	Norman A. Welch, M.D.
Executive Secretary.	Dwight O'Hara, M.D.
<i>New Hampshire:</i>	<i>Vermont:</i>
C. R. Metcalf, M.D.	Frank C. Angell, M.D.
Ralph W. Tuttle, M.D.	John W. Brownlee, M.D.

*Guests:* Frank J. Lawless, M.D., secretary, Board of Registration in Medicine, Vermont; Harold Q. Gallupe, M.D., secretary, Board of Registration in Medicine, Massachusetts; John A. Bolster, M.D., secretary, Board of Registration in Medicine, Rhode Island; John S. Wheeler, M.D., secretary, Board of Registration in Medicine, New Hampshire; Leroy E. Parkins, M.D., chairman of 1946 Postgraduate Assembly (N.E.); Mr. Robert St. Boyd, executive secretary, Massachusetts Medical Society.

Mr. Farrell, executive secretary-treasurer, submitted the following report:

"The minutes and supplemental reports of the previous meeting were mimeographed and sent to each representative of the Council in a bound file for future reference. Correspondence has been carried on for the Council with various groups, and the meeting of the secretaries and other members of state boards of medical registration has been completed for the president through the executive secretary.

"Conferences were held with officials of the American Medical Association in Chicago at the time of the December meeting of the House of Delegates. In particular the plan for two New England radio broadcasts for the AMA centennial year program were discussed.

"Contributions of \$100 each from the six New England State Medical Societies toward expenses of the Council during the year April, 1946, to April, 1947, have been received and deposited with the Industrial Trust Company in Providence. Expenses of the Council have been paid with approval by the President. The bank balance as of January 15, 1947, is \$589.05."

Dr. Metcalf reported on the proposal that the Council of the New England State Medical Societies sponsor the New England Postgraduate Assembly starting with the meeting in 1947 which is tentatively planned for Boston on October 29, 30 and 31.

Dr. Metcalf read a prepared statement relative to the proposal of the past experience of the Assembly, the tenta-

tive plans for 1947, and then questioned whether or not the Council wished to sponsor the program.

After considerable discussion a motion was made by Dr. Tighe that the Council of the New England State Medical Societies postpone action for the present relative to sponsoring the New England Postgraduate Assembly until it can obtain the point of view of the individual state medical societies regarding their participation as co-sponsors. The motion was seconded and adopted.

The executive secretary suggested that some definite proposal should be sent to the various societies to explain fully what would be contemplated if the Council were to take over the Assembly. Dr. Parkins reported that the committee that will be drafted in February by the Massachusetts Medical Society could be requested to take on this added task of notifying the other New England Societies. Mr. Brownlee suggested further that some estimate of the cost of operation of the Assembly to each state Society in case of a deficit be included.

### AMA CENTENNIAL BROADCASTS

Dr. Metcalf reported that the AMA centennial broadcasts would include two from New England, one for the northern New England states, and one for the southern. Dr. Carter of Maine reported that Dr. Forrest Ames of Bangor would be the speaker for the broadcast from northern New England to be given on February 8. Mr. Farrell reported that the date of the southern New England broadcast has been tentatively set for May 31, and that Dr. James R. Miller of Hartford would be the local speaker.

Dr. Metcalf suggested that each of the state societies be urged to publicize the broadcast. Therefore, the Council went on record as recommending that each state society publicize in every way possible the centennial broadcasts of the AMA with particular reference to the two broadcasts from New England.

### HOSPITALS IN THE POST WAR WORLD

Dr. Metcalf, reporting for the sub-committee of the Council representing the New Hampshire delegation on the subject of hospitals, read the summary of a very complete report submitted by his committee. This summary is as follows:

"We suggest then the following trend in hospitalization in the post war world:

"1. Expansion of the general hospital, with increasing acceptance of communicable diseases, of certain types of tuberculosis, of nervous and mental ailments and, perhaps in separate pavilions, of care for patients in the convalescent and chronic stages.

"2. Increasing subsidies from the federal government, the state or the county. The Hill-Burton bill provides a subsidy. For "relief" patients the government under its different programs pays only about 50 per cent of the actual cost of medical care. The government should pay the entire cost for the individual so classified.

"3. Extension of physical and occupational therapy.

"4. State licensure for all institutions that care for the sick, supervised, we hope, by one agency.



"5. Responsible boards of trustees who will cooperate with the medical staff and with a sure-fire administrator who has his feet on the ground.

"6. Two groups of nurses, besides the graduates. The first group with better background and a longer training period; a second group for the simpler tasks with briefer training.

"7. Higher wages for nurses and for all hospital personnel. The American Hospital Association is working on the problem of pensions. Social Security does its part, but it should be furthered by a fund contributed by the hospital and the employees themselves.

"8. An increase in the number of doctors who have their offices in hospitals and an increase in group practice.

"9. A gradual increase in the cost of hospital care which will be materially alleviated by insurance plans.

"10. Public health centers in areas of scanty population, rather than an increase of small hospitals.

"11. Closer coordination among hospitals, perhaps under the sponsorship of hospital councils."

Dr. Metcalf called for discussion.

Dr. Pitts cited the proposal relative to nurses and stated that the nursing situation promised to become very critical. He reported that he had been informed that there had been no applicants for the new nursing class at Rhode Island Hospital which was scheduled to start in February.

Dr. Rice of Massachusetts discussed the program in that State for licensed attendants, reporting how applicants for such privilege take a course from 16 to 18 months in schools approved by the Massachusetts Approving Authority, and trained as nurse attendants they are paid approximately 60 per cent of the professional nursing fee. Dr. Gallupe, secretary of the Massachusetts Board of Registration, explained in detail the workings of the Board. He stated that it had approved eleven schools for licensed attendants, with courses running from one year to eighteen months. He expressed the feeling that it was an excellent method to provide nurse auxiliaries, and he stated that the Board had issued the curriculum for the licensed attendants as the result of a cooperative action by the physicians and nurses in Massachusetts. While licensed attendants are allowed to serve in hospitals, he reported that the bulk of their work is home nursing. He further reported that Boston University was planning to inaugurate a five-year course in its new school program.

Dr. Howard discussed the problem of nurses in hospitals and stated that professional nurses should not have to carry on the routine duties that could be delegated to aides. Dr. Yeager of Connecticut stated that at a recent nurses' meeting in Hartford there had been much discussion of why nurses will not start training because of the conflict between nurses with college education and those with high school training. He also reported that industry had attracted many nurses and nurse personnel.

#### LABOR RELATIONS

Speaking for the Massachusetts delegation to whom the topic, "Labor Relations," had been assigned, Dr. Tighe cited the two questions proposed: (1) the advisability of meeting with labor leaders, and (2) the discussion of mutual problems regarding health and welfare. He recommended that for the time being action on a meeting be postponed. He amplified

his reason with remarks off the record.

Dr. Tighe also remarked that it was the general feeling of labor that industry should pay the costs of medical care; while industry feels that the main expense involved in assisting in medical care for employees, other than in-patient plant service, is to accept the cost of services involved for pay roll deductions, etc., to enable employees to purchase insurance, both from non-profit and from casualty carriers. Dr. Welch remarked that one employer angle of opposition has been the fact that wage increases are known and publicized, but insurance benefits are not given equal publicity; hence employers are not too favorably inclined to expand or continue some of their programs now in operation.

#### HEALTH EDUCATION

Dr. Hermon C. Pitts of Rhode Island reported that the sub-committee assigned the topic of "Health Education" had decided to concentrate on the matter of statewide health federations or councils under the sponsorship of the medical societies.

In the discussion of Dr. Pitts' report, Mr. Farrell inquired what states had a Division of Health Education in the Department of Health. Massachusetts reported an adult education program that is not specifically a health education plan as generally understood in the proposal outlined in some of the states such as New York. Dr. Angell of Vermont spoke of the development of the State Health Council in Vermont and told of some of the projects it hoped to attack.

#### MISCELLANEOUS BUSINESS

Dr. Metcalf asked the opinion of the members relative to whether they felt the Council was serving a useful purpose. The consensus was that the Council had proved itself in the past two years as an excellent mechanism for bringing together the president and secretaries and other officers to discuss mutual problems. All present were in agreement that they had gained much from the open discussion of what is being done in neighboring states.

With such an expression of approval, Dr. Metcalf stated that he would therefore name a nominating committee consisting of Dr. Welch of Massachusetts, Dr. Angell of Vermont, and Dr. Carter of Maine, to bring in a slate of officers at the annual meeting on April 16 to serve for the term 1947-48.

The meeting was adjourned for dinner and was reconvened at 8:00 P. M.

#### LEGISLATION

The Vermont delegation to which had been assigned the subject of "Legislation" reported on its problem relative to professional licensure in Vermont. Dr. Angell stated that after careful study the Vermont State Medical Society plans to introduce a new medical practice act. He asked Mr. Brownlee to discuss it. Mr. Brownlee reported that the Society had reviewed the problem of the osteopaths in Vermont and as a solution to the problem, as well as a method to raise the standard of licensure and educational requirements for all healers, it had decided on legislation to provide for a composite board consisting of four doctors of medicine, two osteopathic physicians, and one chiropractic physician. The legislation would also provide for an approving board which would rate the schools for all healers for eligibility for application through licensure in Vermont.

Dr. Howard reported on a recent experience in Connecticut relative to a ruling which allowed a natureopath from a southern state to establish himself in Connecticut on the basis of reciprocity. Dr. Gallupe pointed out that the use of the word "endorsement" is much more desirable than that of reciprocity, which implies a contractual agreement.

#### MEDICAL LICENSURE

At the request of the committee of the secretaries of the Boards of Medical Examiners who had been invited to the meeting at the request of the Council to discuss the problem of medical licensure in New England, Dr. Gallupe reported that Massachusetts would register graduates of approved schools if licensed in another state, and the applicant must appear before the Board. He stated that Rhode Island had now consented to do the same thing and, likewise, Connecticut, Vermont and New Hampshire. Maine is unable to work out such an agreement as the State cannot accept men except by reciprocal agreement between states.

The report of the Medical Examining Boards' secretaries was discussed briefly, and they were commended for their action in bringing about such a unanimity of opinion between the states on this important matter.

#### MISCELLANEOUS BUSINESS

The executive secretary discussed the advisability of purchasing for distribution to the Council copies of the publication entitled "Blueprint for the Nationalization of Medicine" by Marjorie Shearon. He quoted that in quantity, fifty copies could be purchased for \$10.00. It was moved that the secretary purchase copies for distribution to the members of the Council. The motion was seconded and adopted.

The executive secretary reported that he had received an inquiry from the editor of the CONNECTICUT STATE MEDICAL JOURNAL relative to the possibility of securing minutes and reports of the Council meeting for possible use in his publication. The Council approved of the sending of the minutes and the reports of meetings to the editors of the Journals in the New England States.

Dr. Metcalf called attention that the annual meeting would be the next meeting, unless the Council decreed otherwise, and would be held at Boston on Wednesday, April 16, 1947. He suggested that, if possible, the next meeting be held at the Harvard Club. He called for suggestions for the program of the meeting, asking if it would be the wish of the Council to have a speaker. Mr. Farrell suggested the possibility of having Mr. Charles Swarts, the new assistant to the secretary of the American Medical Association, as a speaker on the subject of "Medical Public Relations." After discussion it was agreed that the question of whom to invite to address the Council be left to the president and to the executive secretary.

The meeting adjourned at 8:30 P. M.

Respectfully submitted,

John E. Farrell

Executive Secretary

## Penicillin in New Form

Actual production of penicillin in the purest and most potent form yet developed commercially was announced recently by the Heyden Chemical Corporation. Known as white crystalline penicillin, this new form of the drug can be stored in its dry state for three years without refrigeration, twice as long as the familiar yellow product, which requires refrigeration. Described as a major advance in the penicillin field, production of the new white crystalline type comes after more than two years of research in the Company's Princeton laboratory.

In January 1944 penicillin as it was then known was required to contain approximately 250 active penicillin units per milligram. The maximum possible potency for the G type was set up by the Pure Food and Drug Administration as 1,667 per milligram. Subsequently, penicillin potency was lifted to more than 1,000 active units. The new product approximates the 1,667 units set up as the maximum possible potency for its type. It is the G type, most thoroughly researched of those already known, which is used as the basis of the white crystalline form.

The ordinary yellow penicillin must be stored under refrigeration and government regulations require an 18 months' dating, which means it should not be used when it is more than a year and a half old. The new crystalline type in its dry form can be stored without refrigeration for at least three years. This feature permits long distance transportation of the drug without refrigeration even in tropical areas. One of the rigid tests required by the Food and Drug Administration demands that it withstand a temperature of 212 degree Fahrenheit, at which water boils, for six days without appreciable loss of value.

Like previous types, the new white crystalline penicillin when in solution must be kept under refrigeration unless used immediately.

Where previous important advances in the development of new strains and greater yields from various penicillin molds were originated largely by research organizations and universities, the production of this purer penicillin can be attributed exclusively to the industry.



WOMAN'S AUXILIARY

TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. JAMES DOUGLAS GOLD, Bridgeport*  
*President-Elect, Mrs. ALFRED LABENSKY, New London*  
*First Vice-President, Mrs. FREDERIC W. WERSEBE, Washington*  
*Second Vice-President, Mrs. JAMES RAGLAN MILLER, Hartford*

*Recording Secretary, Mrs. CHARLES W. GOFF, West Hartford*  
*Corresponding Secretary, Mrs. EDWIN R. CONNORS, Bridgeport*  
*Treasurer, Mrs. FRANK DiSTASIO, New Haven*

Board of Directors Meeting

The Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society held a luncheon meeting on Wednesday, January 29, 1947 at the Y. W. C. A. in Hartford. The business meeting was called at 11:30 A. M. by the president, Mrs. James Douglas Gold, and the reports of the officers and standing committees were heard.

The program for the annual spring meeting of the Auxiliary, which is to be a luncheon at one o'clock at the New Haven Country Club followed by the business meeting and afternoon program, was presented by the program chairman, Mrs. James R. Miller. Mrs. Miller's committee was empowered to proceed with the suggested program.

Mrs. Paul S. Phelps, president of the Hartford County Auxiliary, reported that they have completed a membership drive and have two hundred and thirty-two interested paid up members. The final news letters for this year have been mailed to all active members in the country. During the first week of January a study group met at the home of Mrs. James R. Miller. Following a very interesting talk by the State Legislation Committee chairman, Mrs. Robert J. Cook, on "State Legislation," tea was served. The February calendar includes a Program Committee meeting on February 7 to complete plans for the annual spring meeting to be held on April 1. On February 18 the Auxiliary will have a reunion and get-acquainted luncheon and bridge at the Wampanoag Country Club, West Hartford. There will be a study group meeting on February 24 with Dr. Grace Mooney as guest speaker. Mrs. J. Whitfield Larrabee is in charge of tickets for the Welfare Fund musicale which was postponed from last November. The date is Saturday, March 15, 1947; the place, Town and County Club, Woodland Street, Hartford, at 8:30 P. M. Price \$1.50. Mrs. Larrabee will forward tickets on receipt of check. The artists on the program are Mrs. Louis Spekter,

vocalist; Mrs. Peter J. Scafarello, violinist; and Mrs. Robert Buell, pianist. Mrs. Phelps has appointed Mrs. Gilbert W. Heublein as the new War Service and Post War Committee chairman.

The Executive Committee of the Fairfield Auxiliary held a meeting at the home of Mrs. Harold L. Amos, president of the Fairfield County Auxiliary, on January 21. Mrs. Edwin Trautman of Long Hill was appointed Public Relations chairman. An executive meeting is scheduled at the home of Mrs. William Geer on February 17 at which time the plans for the spring meeting will be completed. Officers for the ensuing year will be presented at this meeting.

The fall meeting of the Litchfield County Auxiliary was held on November 12, 1946 at the home of the president, Mrs. Frank L. Polito of Torrington. Mrs. W. Bradford Walker, chairman of the Membership Committee reported eight new members, and the guest speaker, Miss Pauline Crandall, gave an interesting talk on "Child Welfare." The annual meeting is planned for April.

At an executive meeting to be held soon the Middlesex County Auxiliary will complete plans to have their annual spring meeting coincide with the date of the Middlesex County Medical Association meeting.

Mrs. Creighton Barker, president of the New Haven County Auxiliary, reported that Mrs. J. Harold Root, chairman of the Legislation Committee, had submitted her resignation because she was moving to Litchfield County. Mrs. John Foster was appointed as the new chairman for this committee. The resignation of Mrs. Robert Lewis, chairman of the Public Relations Committee, was also reported, but a new chairman has not been appointed. The New Haven Auxiliary manned a booth for the sale of tuberculosis seals during the Christmas period. Board meetings were held in November 1946 and January 1947 and the annual meeting is planned for

March 27 at the Oakdale Tavern in Wallingford. The guest speakers will be Dr. Creighton Barker and Mrs. Ralph McDonnell who will talk on "Health Bills." Members of various Social Agencies will be invited to attend this meeting. A letter, commending the article on socialized medicine which appeared in the February issue, was written to the editors of *Better Homes and Gardens*.

Mrs. Harold W. Wellington, president of the New London Auxiliary, reported that a board meeting would be held in March to make plans for the annual meeting in April. The Woman's Auxiliary of the Lawrence Memorial Hospital have started the Dorothy Labensky Memorial for Cancer Equipment for which eighteen hundred dollars already has been raised and some equipment purchased. Plans for raising further funds include a bridge party, proceeds of which will be donated to the Memorial.

Mrs. Robert J. Cook, chairman of the Legislation Committee, reported that she was following the federal bills and that the states were to take care of their own health legislation. She is waiting until February 7 to see what bills are submitted to the legislature.

Mrs. G. Gardiner Russell, chairman of the War Service and Post War Planning Committee, reported that no bill for medical care was advocated in the legislature. Insurance companies are to submit plans to the Connecticut State Medical Society committee, which will act as an advisory committee, backing any company submitting an adequate plan, for it is felt that professionals can do a better job than amateurs in mapping out proper coverage.

Mrs. Dewey Katz, chairman of the *Hygeia* Committee, reported that she had written to Dr. Gilman about getting *Hygeia* into the schools, and she has received permission to do so, and has also learned that fifty per cent of the schools are using *Hygeia*. The project for auxiliaries as planned by Mrs. Edson, National chairman, included a survey of the state to determine where *Hygeia* is found: i.e., schools, offices, etc. She did not feel that we had well set-up committees to handle the survey and requested a round table discussion with county chairmen at the annual meeting.

Mrs. Katz, who has done a splendid piece of work during the year, has been appointed Eastern Regional chairman of the National *Hygeia* Committee.

Mrs. Joseph H. Howard, chairman of the Publicity Committee, reported that more material was

needed and requested presidents of the auxiliaries to check with their chairmen for the purpose of having editorials and other material printed in the *CONNECTICUT STATE MEDICAL JOURNAL*.

The Board decided to have all annual reports mimeographed for the state annual spring meeting. This material must be sent to the corresponding secretary, Mrs. Edwin R. Connors, by April 15.

## Encore Chicago

Because our president, Mrs. James Douglas Gold, was in the Bridgeport Hospital saying farewell to her appendix, and because our president-elect, Mrs. Labensky, was so tragically ill, neither could go to Chicago for the Annual Conference of Presidents, Presidents-Elect of State Auxiliaries, and Chairmen of Standing Committees of the Woman's Auxiliary to the American Medical Association. As I was in Chicago at the time, Mrs. Gold asked me to attend the conference which was held at the Hotel Continental, December 11 and 12.

It was unfortunate that we were leaving for New York on the afternoon of the 11th and reservations being what they are both in hotels and on trains, a change was not possible but I did attend the opening session and on that I will make a short report which is nearer putting down my impressions. The business of the conference will be published in the next *Bulletin* which I hope all auxiliary members will read.

Mrs. Eustas Allen of Georgia, president-elect of the Auxiliary to the American Medical Association, presided at the meeting. Mrs. Allen had very recently broken her leg and was there in a plaster cast, on crutches and in no little discomfort. It certainly was an exhibition of courage and endurance.

After we were called to order, the pledge of loyalty was recited in unison. This was quite impressive. Then Mrs. Jesse Hamer, our national president, welcomed us in her usual gracious manner.

To me the roll call was interesting as fifty-one delegates answered the call from thirty-three states, covering the most southern and most western states, plus little Connecticut—the most eastern of all.

John H. Fitzgibbon, M.D., a member of the Board of Trustees, came in about 10:30 and spoke for twenty minutes or so most forcefully on the opportunities there are for the women of the Auxiliary to be really useful in the overall program of the A.M.A.



He spoke feelingly on how the reprehensible actions of a few will reflect on the whole and that the physicians were next to the clergy or should be in their high standards of conduct in the office and in the home.

Mr. Hollaway of the A.M.A. Bureau of Legal Medicine talked to us on legislation and the probable bills that would be presented to the 80th Congress, especially Senator Taft's bill asking for a department of medicine.

Mrs. Kice, chairman of the Auxiliary Legislative Committee, spoke after Mr. Hollaway and suggested that we form study groups within our county organizations and recommended the pamphlet "Voluntary Health Insurance Versus Compulsory Sickness Insurance" which is put out by the Committee on Medical Services.

At the luncheon meeting I, in wifely pride, heard my husband address the women on the work of the Service Committee of the American Cancer Society. As chairman of that committee he explained the service program to which the House of Delegates of the A.M.A. had just given its approval. This program deals with cancer patients and prospective cancer patients. It was made clear that the Cancer Society subsidizes local programs which must first be approved by the County Medical Associations. The College of Surgeons will inspect for approval the cancer clinics just as it does the hospitals throughout the country.

Elisabeth W. Miller

Rhode Island Forms a Woman's Auxiliary

On February 5 Dr. Pitts of Providence, Rhode Island, met with almost 100 wives of members of the Rhode Island Medical Society at the Providence Medical Association building. This group voted to form a Woman's Auxiliary. Mrs. James R. Miller of Hartford, vice-chairman for organization of the Woman's Auxiliary of the A.M.A., addressed the meeting, having been given this assignment by the national chairman of the Committee on Organization of the National Woman's Auxiliary. The president of the new Woman's Auxiliary to the Rhode Island Medical Society is Mrs. Herbert E. Harris of Providence.

X-rays Show Unborn Child of 12 Weeks Breathes, Swallows

Two Chicago doctors have demonstrated by means of a dye and x-rays that the important functions of breathing and swallowing develop as early as the 12th week in an unborn child.

Writing in the August 10 issue of *The Journal of the American Medical Association*, the authors—M. Edward Davis and Edith L. Potter from the Department of Obstetrics and Gynecology, the University of Chicago School of Medicine and the Chicago Lying-in Hospital—state that these experiments were carried out on two groups of patients: one made up of 16 women, who, because of some serious maternal complication, had to have their pregnancy terminated in the first half of the period and the second consisted of 10 women who were delivered by a cesarean operation.

The dye, opaque to x-rays, was injected into the sac containing the fetus. From 17 to 52 hours later the pregnancy was terminated and the fetus was sent to the x-ray laboratory. The first group of fetuses showed the dye in all parts of the lungs, in the stomach and throughout the intestinal tract, demonstrating that the fetus aspirated the fluid within the sac and exhaled it. Thus there is evidence that the fluid normally moves in and out of the lungs.

The second series of patients, who were delivered by cesarean operation, were treated in the same manner. X-ray examination of the infants' lungs immediately after delivery showed evidence of the dye in five, probable presence in two and no definite evidence in three.

The authors point out that the "general pattern of respiratory activity is developed very early in fetal life." During this period the respiratory movements are intermittent, irregular and shallow. "At birth air is substituted for fluid, and respirations become deeper, regular and continuous, but the pattern remains the same. The major change involves the substitution of air for fluid as a medium of exchange."

In conclusion Drs. Davis and Potter state that "fetal swallowing and complete gastrointestinal activity has been demonstrated for the first time in a human fetus (12 weeks old) weighing 39 grams."

## CORRESPONDENCE

### VETERANS ADMINISTRATION

95 Pearl Street  
Hartford 4, Conn.

January 31, 1947

To the Secretary of the Connecticut State Medical Society:

Your cooperation in recruiting and editing lists of fee basis physicians for this office is greatly appreciated.

We are well aware that without the past and continuing cooperation of the Connecticut State Medical Society, this program would not be a success. The physicians' response to our "Request for appointment as fee basis doctor" was beyond our expectations.

I wish to take this opportunity to thank all members of the Connecticut State Medical Society who have expressed their willingness to act as fee basis physicians for the Veterans Administration. I am positive that the veterans in the State of Connecticut are assured of medical care which is second to none.

My office will always be open to any doctor who has a particular problem concerning the treatment of our veterans.

Very truly yours,  
F. J. Ryan, M.D.,  
Acting Chief Medical Officer

I shall be here for eighteen months, and if any one wants dope on the trip or the West Coast my address is 1410 East 125th Street, Seattle 55, Washington.

Very sincerely yours,  
Charles E. Sanford, M.D.

### FEDERAL SECURITY AGENCY

U. S. Public Health Service  
Washington 25, D. C.

February 2, 1947

To the Secretary of the Connecticut State Medical Society:

A while ago you asked if I would like to know about any interesting work that might appear in Connecticut. I would, and should appreciate your keeping me in touch. My family are still in Wethersfield, and the state still looks good.

That does not mean that anything has happened here. I meant to write you at the time, but simply let the days pass. The work here continues interesting and valuable, and I am associated with pleasant and capable people.

I spent yesterday at the symposium on antibiotics. It is a good thing to get away from one's own desk once in a while. They have indeed made progress, and things are very encouraging. Cures in a substantial percentage of TB meningitis!

I hope to send the editor a manuscript soon. With which threat I close.

Sincerely yours,  
Henry R. O'Brien

To the Editor:

Many thanks for the JOURNAL which reached me up here in Seattle. It has occurred to me that some of our colleagues might have missed me at the regular convocations, so if and when you have space in your JOURNAL you might tell them that on September 5 I left New Haven for the West Coast, driving via Niagara Falls, Chicago, then over the so-called Painted Desert route through St. Louis, Oklahoma City, Amarillo, Albuquerque, Flagstaff, taking in the Grand Canyon, on to Los Angeles and Oakland where I visited two of my brothers, and on to Berkeley. I stayed at Berkeley from September 16 till November 8, then drove on to Seattle where my niece, a registered nurse who served three years in the Navy, is taking a course in public health at the University of Washington.

### Chemotherapy in Wounds

"Chemotherapy in the Management of Wounds" by Champ Lyons in *The Journal of the A.M.A.* for January 25, 1947, deserves wide distribution and strong emphasis. The conclusions are especially heartening to your editor because in "The Essentials of Emergency Treatment" published by this JOURNAL in 1942, it was questioned whether the local use of the sulfa drugs was desirable. It also was suggested that it would be unwise to abandon established surgical principles whatever might be the final evaluation of the sulfonamides. Now here are the conclusions of an authority on the problems of infection. "Suppuration of the wound is an indication for a surgical procedure." And, "Local chemotherapy is unnecessary and undesirable."



SPECIAL NOTICES

POSTGRADUATE COURSES IN RADIOLOGY

The American College of Radiology has arranged a postgraduate course to be held in the lecture hall of the Philadelphia County Medical Society March 31 through April 4, 1947. The fee is fifty dollars (\$50.00) and checks should be made payable to The American College of Radiology. Application blanks should be mailed to The American College of Radiology, Postgraduate Courses, 20 North Wacker Drive, Chicago 6, Illinois. This course will include a presentation and discussion of the following subjects: Dosage Calculation and Tumor Sensitivity in Radiation Therapy; Carcinoma of the Head and Neck; Carcinoma of the Breast; Blood and Hemopoietic Diseases; Carcinoma of the Genital and Urinary Tracts and Benign and Malignant Diseases of the Skin-Infections. There will be a banquet on Friday, February 4 at 7:00 P. M. at the Warwick Hotel.

STERILITY SOCIETY CONVENTION

The third annual convention of the American Society for the Study of Sterility will be held at the Hotel Strand, Atlantic City, New Jersey, on June 7 and 8, 1947, preceding the annual A.M.A. Convention. The general theme of the meetings will be that of attempting to disseminate to the physician treating marital infertility an overall picture of the latest advances in reproduction. The convention will include original papers, round table discussions, scientific exhibits, and personal demonstrations. Registration for the sessions is open to members of the medical and allied professions.

Additional information may be obtained from the secretary, Dr. John O. Haman, at the above address.

CONFERENCE ON SOCIAL HYGIENE

Once again the Connecticut Tuberculosis Association in cooperation with the State Department of Health will sponsor a conference on social hygiene on March 5, 1947. Mr. Roy Dickerson, Executive Secretary, Cincinnati Social Hygiene Society and author of the Home Study Course on Social Hygiene Guidance, will be the guest speaker. Full details as to place and time will be found on the following page.

OPHTHALMOLOGISTS' DIRECTORY

A directory of all diplomates to January 1, 1947, will be published shortly after that date.

This directory will be arranged alphabetically and geographically. No biographical material will be included.

Every effort will be made to make this directory accurate and diplomates who have not already done so should notify the Board office at once stating their name and address exactly as they wish them listed.

Price is \$3 postpaid.

Note: Diplomates are requested to keep the Board office informed of all changes of address so that the files may be kept up-to-date.

Officers for 1947. Dr. Goar, chairman; Dr. Theobald, vice-chairman; Dr. Beach, secretary-treasurer.

1947 examinations: Atlantic City, June 8-13; Philadelphia, June 13-16; Chicago, week of October 8.

Executive office: American Board of Ophthalmology, Cape Cottage, Maine.

1947 CONGRESS ON OBSTETRICS AND GYNECOLOGY

The program of the Third American Congress on Obstetrics and Gynecology is to be held September 8-12, 1947, in St. Louis will feature general sessions for all groups making up the Congress as well as small individual group meetings and round table discussions. The morning sessions will be panel-type presentations of the following subjects: Tuesday, September 9: Anesthesia and Analgesia; Wednesday, September 10: Cancer; and Thursday, September 11: Caesarean Section.

The afternoon meetings of the medical section of the Congress will consider on Tuesday: Psychosomatic Aspects of Pregnancy; on Wednesday: Pregnancy Complicating Cardiac Disease, Diabetes and Tuberculosis; and on Thursday: Recent Advances in Endocrinology.

Round Table discussions from four o'clock to five daily will consider such topics as etiology of abortion, asphyxia, fibroid, prolonged labor, infertility, early ambulation, adolescence, treatment of abortion, genital relaxation, ovulation, the menopause, the cystic ovary, uterine bleeding, nutrition in pregnancy, geriatric gynecology, endometriosis and erythroblastosis.

Concurrent sessions and round tables for nurses, hospital administrators and public health workers are being arranged.

The popular forceps and breech demonstrations that attracted so much attention at the Second Congress in 1942 will be increased in number so that eighteen demonstrations per day will be held, six each at nine, one and five o'clock daily.

A large Scientific and Educational Exhibit is being set up under the direction of Dr. J. P. Pratt of Detroit and a comprehensive Motion Picture Program is being arranged by Dr. John Parks of Washington, D. C. The committees assisting these doctors will review applications by prospective participants late this spring. Anyone wishing to make application for space in the Scientific Exhibit or for time on the Motion Picture Program may obtain the proper blanks from the office of the Congress at 24 West Ohio Street, Chicago 10, Illinois.

## Social Hygiene Conference Planned for Hartford, March 5

The Connecticut Tuberculosis Association, in cooperation with the State Department of Health and Parent-Teacher Association of Connecticut, is sponsoring a Conference on Social Hygiene at the West Middle School, 927 Asylum Avenue, Hartford, on March 5 from 2:00-5:30 P. M. Mr. Roy Dickerson, executive secretary of the Cincinnati Social Hygiene Society and author of the Home Study Course on Social Guidance which has been widely used throughout the State, will be the guest speaker. Mr. Dickerson's topic is, "The Parents' Part in Sex Education."

For many years Mr. Dickerson has been widely known as a writer, speaker, and consultant among young people and adults. He received his LL.B. degree from the University of Denver and LL.M. degree from George Washington University. His experience includes work with the Y. M. C. A., and director of activities of the Grand Council of the Order of De Molay. He serves as a consultant for the American Social Hygiene Association and United States Public Health Service. He is also acting associate professor, Teachers College, University of Cincinnati.

Following is a complete resume of the program:

2:00 Registration and Exhibits.

*Introduction:* Dr. Grace Mooney, chairman, Committee on Social Hygiene Information, Connecticut Tuberculosis Association, and executive assistant, Connecticut State Medical Society

"The Parents' Part in Sex Education," Mr. Roy Dickerson, executive secretary, Cincinnati Social Hygiene Society

Panel Discussion

"Community Resources Available to Parents"

*Moderator:* Mr. Roy Dickerson

*By a Psychiatrist:* Dr. Frances Ilg, assistant professor of Child Development, Yale University

*By Parents:*

Mrs. Kirby Broderick, president, West Haven Parent-Teacher Council

Mrs. John Sayers, president, Sedgwick Parent-Teacher Association, West Hartford

*By a School Administrator:* Mr. Raymond Walker, principal Meriden High School

*By a Clergyman:* Rev. Charles Hutchinson, chairman, Committee on Family Life, Connecticut Council of Churches

*By a Group Worker:* Mrs. Elizabeth W. Clarke, health education director, Hartford Y W. C. A.

## Second Annual Connecticut Industrial Safety Conference, March 5, 1947

Hotel Bond, Hartford

MORNING SESSION

9:30 A. M.

WELCOME TO DELEGATES

President of Connecticut Safety Society  
Mayor of Hartford

PUTTING THE PUNCH IN SAFETY

W. T. Cameron, director, Industrial Vision, American Optical, Southbridge, Mass.

*Chairman:* Leroy J. McCarty\*

RECESS

11:00-12:00

ACCIDENT PREVENTION BY INVESTIGATION

Fred Schatzman,\* Chance Vought

R. Perry,\* Electric Boat Company

C. R. DeReamer,\* General Electric

W. McChesney,\* Scovill Manufacturing Company

P. Van Tilden,\* Mfg. Chemist Association

*Chairman:* Frank Louglin\*

AFTERNOON SESSION

1:45-2:45 Old English Room

THE NURSE'S PARTICIPATION IN ACCIDENT PREVENTION

Dr. Crit Pharris,\* United Aircraft Corp.

*Chairman:* Mildred Kane, president Hartford Branch, New England Industrial Nurse Association

2:00-2:45 Grand Ballroom

SAFE USE OF X-RAY, RADIUM AND RADIO ACTIVE MATERIALS IN INDUSTRY

Dr. Carl B. Braestrup, senior physicist, Department of Hospitals, City of New York

*Chairman:* Dr. Albert S. Gray

RECESS

PSYCHOLOGY OF ACCIDENT REPEATERS

Dr. Philip J. Moorad

*Chairman:* Dr. John Gallivan\*

SAFETY DRAMATIZED FOR SUPERVISION

William Visokay,\* director of safety, Bridgeport Brass Co.

*Chairman:* Everett W. Martin\*

\*Members of Connecticut Safety Society

BANQUET

6:30 P. M.

GUEST SPEAKER

CARL M. LINGE

General Manager General Electric, Bridgeport

## YALE UNIVERSITY THE SCHOOL OF MEDICINE

### Announcements of Fellowships in the Biological Sciences

The James Hudson Brown Memorial Fund was established in 1944 by bequest of Marie B. C. Brown in memory of her husband. The income provides for research grants and for research fellowships. The fellowships are open to promising investigators for the prosecution of research in the medical sciences, including clinical medicine and public health.

The Alexander Brown Coxe Memorial Fellowships in the Biological Sciences were established in 1927 by a gift from the family of the late Alexander Brown Coxe, B.A. 1887. The income is awarded annually to one or more investigators



in the field of the biological sciences, including medicine.

Preference for the Brown and Coxe postgraduate fellowships is given to university graduates who hold the M.D. or Ph.D. degree, and who have previously demonstrated their fitness to carry on original research of a high order.

No credit toward a degree can be obtained during the tenure of any Fellowship except by special permission of the Committee on Funds and Fellowships.

Fellowships are assigned ordinarily for a single year. The amount of the award will be determined for the individual applicant. An additional sum may be assigned to the department of study to defray, in part, the cost of the proposed investigation.

The request for a Fellowship Grant must be accompanied by a protocol which outlines the nature and background of the problems to be investigated. Copies of previously published papers should be included. The head of the department in which the applicant plans to study must indicate by letter that the necessary facilities and equipment are available, and that he will assume, directly or through a member of his staff, the responsibility for the direction of the proposed investigation. The faculty member designated must also indicate by letter his acceptance of the candidate.

A report of work accomplished by the recipient of an award is required at the end of the fellowship year. When results of an investigation are published proper acknowledgment of the Fellowship should be included in the paper.

Application forms and additional information may be obtained by addressing the Dean of the School of Medicine, Yale University, 333 Cedar Street, New Haven 11, Connecticut. Applications should be completed and filed prior to March 15.

### TWO WEEKS' REFRESHER COURSE

Cornell University Medical College will offer a two weeks' refresher course of lectures and conferences emphasizing recent advances in Internal Medicine and Neurology. The course will begin April 1, 1947. Fee \$50.00. Address inquiries to John E. Deitrick, M.D., Director, Second (Cornell) Medical Division, Bellevue Hospital, First Avenue and Twenty-sixth Street, New York 16, New York.

### THE AMERICAN OTORHINOLOGIC SOCIETY FOR THE ADVANCEMENT OF PLASTIC AND RECONSTRUCTIVE SURGERY, INC.

The next meeting of The American Otorhinologic Society for the Advancement of Plastic and Reconstructive Surgery, will be held at the New York Academy of Medicine, New York City, February 27, at 8:30 P. M.

#### SCIENTIFIC SESSION

1. New Method of Insertion of Columellar Strut  
Matthew S. Ersner, M.D.  
Temple University School of Medicine  
Philadelphia, Pa.

2. Rhinoplasty in Children  
Irving M. Lefkon, M.D.  
New York, N. Y.

Discussion by  
Francis W. White, M.D.  
New York, N. Y.

3. The Treatment of Epithelioma of the Face  
Maurice Lenz, M.D.  
Columbia University  
New York, N. Y.

### Lasker Awards in Planned Parenthood Given to Dr. Guttmacher and Dr. Stone

Alan F. Guttmacher, M.D., of Baltimore, Md., and Abraham Stone, M.D., of New York City have been named as winners of the third annual Lasker Awards of the Planned Parenthood Federation of America by Dr. Robert L. Dickinson, spokesman for the Federation's Lasker Award Committee.

The awards were given this year for distinguished leadership in marriage counselling. The two winners were selected from many candidates by a three man committee composed of Dr. Dickinson, one of the world's great authorities on gynecology and obstetrics and a winner last year of a Lasker Award of the Planned Parenthood Federation, Dr. Ernest L. Stebbins, former Commissioner of Health of New York City, now at Johns Hopkins University, and Dr. William T. Kennedy, one of the nation's most distinguished obstetricians and gynecologists.

Dr. Guttmacher and Dr. Stone, through their writings, teaching, counselling and clinic services, have led the way in making possible better health for mothers and children, children for the childless, fewer mother and baby deaths, fewer juvenile delinquents and fewer broken homes—all the basic objectives of the Planned Parenthood Federation.

Presented to the Federation by the Albert and Mary Lasker Foundation, the Awards consist of a medallion and a \$500 cash prize for each winner. The medallion, depicting a family group, was designed by 86-year-old Dr. Dickinson. Dr. Dickinson has found time during 65 busy years of distinguished medical practice to make a name for himself as an author, lecturer, sculptor and illustrator of medical subjects.

## THE DOCTOR'S OFFICE

Maxwell H. Bloomberg, M.D., wishes to announce the opening of his office for the practice of orthopedic surgery at 53 Cooke Street, Waterbury.

A. Paul Buchanan, M.D., who served in the Army Medical Corps, recently resumed private practice of medicine in his office, 932 East Main Street, Bridgeport.

Samuel H. Cohn, M.D., who formerly served in the Army Medical Corps, has opened an office for the practice of general surgery at 464 Farmington Avenue, Hartford.

John J. Dobkins, M.D., announces his return from Army service and the opening of an office at 81 Atlantic Street, Stamford, for the practice of internal medicine.

Thomas M. Feeney, M.D., having returned from military service, announces the reopening of his office for the practice of urological surgery at 701 Asylum Avenue, Hartford.

Charles Weer Goff, M.D., announces the association with him of William E. Kenney, M.D., in the practice of orthopedic surgery at 30 Farmington Avenue, Hartford. Dr. Kenney is the author of a number of orthopedic articles and has recently prepared a textbook on fractures for medical students which is about to be published. He is an assistant orthopedic surgeon at Newington Home for Crippled Children and a clinical associate in orthopedic surgery at St. Francis Hospital. He is also a clinical instructor in orthopedic surgery at Yale Medical School.

Neville Kirsch, M.D., announces the opening of his office for the practice of dermatology at 56 Garden Street, Hartford.

Neil F. Lebahr, M.D., who served four years in the medical corps of the Army Air Force, has opened an office for the practice of pediatrics in his home on Bay Street, Westport.

Seymour M. Miller, M.D., a former Army captain, has opened an office for the practice of medicine and surgery at 62 LaSalle Road, West Hartford.

Samuel A. Robb, M.D., having been released from Army service, has opened an office for the practice of urology in the Kassabian Building, 69 East Main Street, Meriden.

Roger G. Robitaille, M.D., who served as Second Lieutenant in the U. S. Army Medical Reserve Corps, has opened offices for the practice of general medicine at 2 Butler Street, Norwalk.

Daniel J. Sabia, M.D., having been released from the U. S. Army, has opened an office at 15 Broad Street, Stamford, for the practice of medicine and surgery.

Stephen M. Smith, M.D., is resuming the practice of neuropsychiatry at 78 Main Street, Westport.

Frank S. Vogel, M.D., a former major in the Public Health Service branch of the U. S. Army, is resuming his practice at 301 Main Street, Bristol.

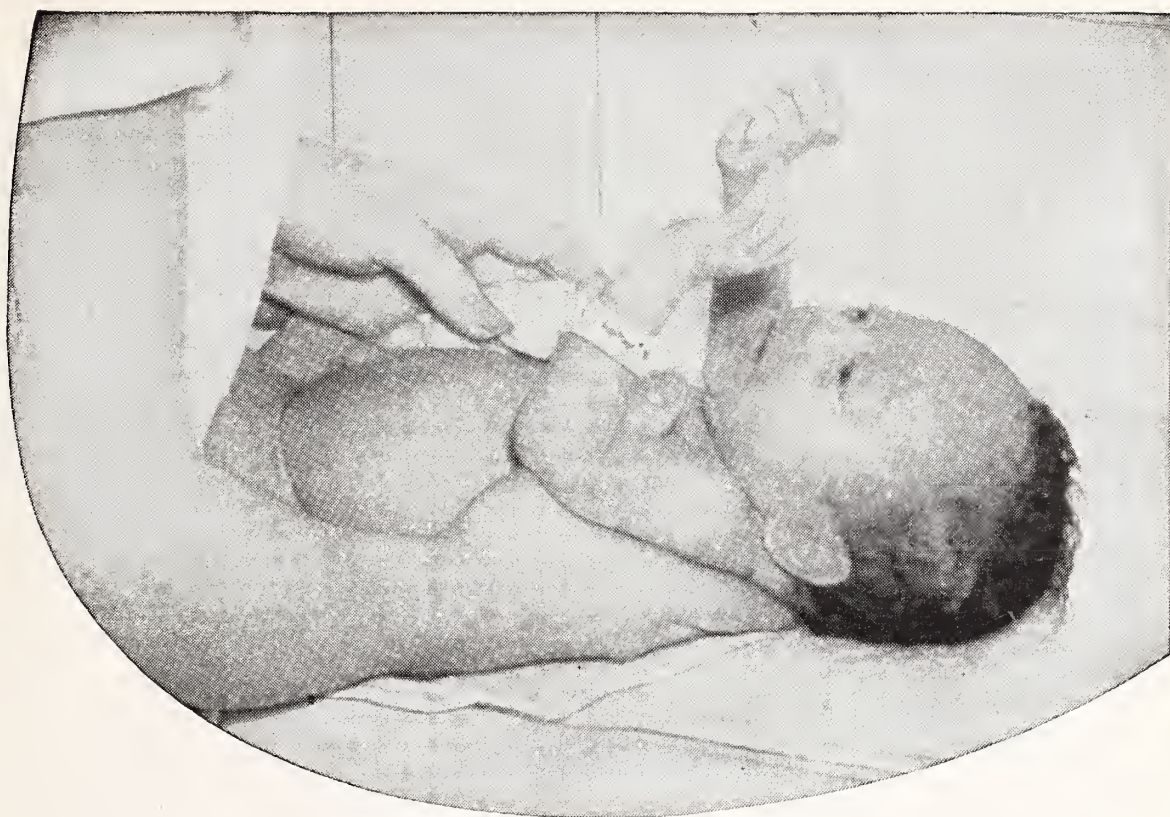
Newell R. Kelley, M.D., announces that beginning March 1 he will be associated in a full time capacity with the medical department of the Phoenix Mutual Life Insurance Company at its home office in Hartford. Dr. Kelley will withdraw from general practice on the above date. His office in Rocky Hill will be maintained by Donald Walker, M.D., who has been associated with Dr. Kelley for the past year.

## OUR NEIGHBORS

### Maine

Plans for a new medical school in Maine seem to be progressing. The president of the Maine Medical Association, John O. Piper, M.D., of Waterville, has appointed a committee selected with a view to broad geographical coverage. A bill will be presented to the State Legislature this year covering the following points: (1) authorization of a medical school; (2) creation of a building commission for the school; and (3) an appropriation of one million dollars to build and equip the buildings. The building commission will have complete charge until the buildings are completed, at which time they are to be turned over to the sole control of the trustees of the University of Maine. It is understood that the trustees are under no obligation to begin operation of a medical school until due appropriation is made to take care of the budget of the school. The University of Maine has no room in its present plant for a medical school nor will it be able to afford any financial backing. It is only two years ago that Adam P. Leighton, then president-elect of the Asso-





## Premature, but promising

To the premature struggling for existence, intestinal distention, colic or diarrhea may be insurmountable obstacles. Good care and good nutrition, however, offer promising prospects for life and health.

In the feeding of premature infants, 'Dexin' has proved an excellent "first carbohydrate." Because of its high dextrin content, it (1) resists fermentation by the usual intestinal organisms, (2) tends to hold gas formation, distention and diarrhea to a minimum, and (3) promotes the formation of soft, flocculent, easily digested curds.

Readily soluble in hot or cold milk, or other bland fluids, 'Dexin' brand High Dextrin Carbohydrate is well taken and retained. 'Dexin' *does* make a difference.

## 'Dexin'

HIGH DEXTRIN CARBOHYDRATE

BRAND

Composition—Dextrins 75% • Maltose 24% • Mineral Ash 0.25% • Moisture 0.75% • Available carbohydrate 99% • 115 calories per ounce • 6 level packed tablespoonfuls equal 1 ounce • Containers of twelve ounces and three pounds • Accepted by the Council on Foods and Nutrition, American Medical Association.  
'Dexin' Reg. Trademark

Literature on request



BURROUGHS WELLCOME & CO. (U.S.A.) INC., 9 & 11 East 41st St., New York 17, N. Y.

ciation, began his campaign to stir up interest in a new medical school.

### Liquor Research Program Inaugurated in New Hampshire

The New Hampshire Liquor Research Commission, according to its secretary, Leon W. Anderson, is attempting to establish an intelligent method of aiding alcohol addicts and to curb excessive use of intoxicating liquors through education.

Membership of the Commission, established by the 1945 State Legislature, represents various interests. Its members include: Charles H. Dolloff, M.D., superintendent, State Hospital; William A. Jackson, chairman, State Liquor Commission; Ernest A. Shepherd, churchman; Lloyd P. Young, president, Keane State Teachers College; Richard J. Stilson, hotel proprietor; Nathan A. Terrill; Leon W. Anderson, journalist.

The Commission, whose members serve without salary, is operating under a small appropriation made available from alcoholic beverage revenues. It has employed two trained men—Professor Michael Choukas of Dartmouth College, and Leon C. Eckman, sociologist, a graduate of the University of New Hampshire.

Two high priority projects on the Commission's docket are a study of public opinion concerning the treatment of alcoholics and the preparation of a new textbook on the subject of alcohol for use in the public schools. The Commission will submit its report to the State Legislature in January 1947.

### New Jersey

*The Journal of the Medical Society of New Jersey* in its January 1947 issue reports on the Medical-Surgical Plan in operation in that state. As of November 30, 1946, there were 84,931 persons enrolled under the Plan's Subscription Contract. In addition 3,297 additional persons were enrolled under subscription contracts with future effective dates, making a total of 88,228 persons. The earned income (subscription income) for November was \$57,815, an average of 68 cents per person. The average number of persons per contract was 2.2. For the eleven months ending November 30, 1946, total earned income was \$480,338. Incidence of treatment was at the rate of 86 per 1,000 persons per year. Operating costs were 17 per cent of earned income and reserves totaled 13.8 per cent of earned income.

While during the past year there have been no appreciable increases in the amounts payable under the schedule of benefits, there has been an expansion of the scope of eligible services to include payment of benefits for (1) tonsillectomies performed in physicians' offices, (2) obstetrical care rendered outside of the hospital at the time of full term delivery, (3) operative procedures in the outpatient department of hospitals without admission as inpatients, and (4) emergency surgical care occasioned by accidental injury rendered within 24 hours of the accident. The cost to the Plan for these additional services is reflected in the reduction in the percentage of reserves accumulated during paralleling periods of 1945 and 1946. The reserves during the same period of 1945 totaled 16.1 per cent of income as compared to 13.8 per cent this last year.

### Sick Benefit Fund Studied in New Jersey

According to *Insurance Economics Surveys*, the merits and disadvantages of a state operated sickness benefit program for workers will be weighed by the commission on Postwar Economic Development before it makes its report to the 1947 Legislature. Some form of sickness benefit program is certain to be recommended to the session.

The proposal that the state take over the \$182,000,000 it has in federal held Social Security funds and use it to set up a state operated program was the subject of a day-long debate at a hearing of the Commission attended by almost 200 representatives of labor and industry.

The \$182,000,000 represent workers' contributions to the unemployment compensation trust fund and under legislation adopted by Congress this year it would be returned to the state if the state desires to set up a state operated sickness benefit fund with it. If the money were taken, about \$245,000,000 would remain in the regular UCC fund.

Early this year the commission recommended a program similar in many respects to the present workmen's compensation law—that employers take out insurance with private companies, act as self insurers or that groups get together and create their own insurance funds.

The new hearing was called to determine whether sentiment has changed since the passage of the federal law permitting return of the workers' contributions to the state. If the money is not claimed by the state for creation of the new fund, it will remain to the UCC's credit.





**to combat**

**depression characterized by**

**"chronic fatigue"**

Depressed patients "...suffering from psychomotor inhibition complain of feeling tired, of not being able to get started on their daily tasks, and of an abnormal inclination to procrastinate. They make up their minds that they are going to do a certain thing but they never seem to get to it. Everything seems too big for them . . ."\*

In the above quotation, Kamman emphasizes "chronic fatigue" as a dominant symptom in the type of depression most frequently encountered in daily practice.

Benzedrine Sulfate is particularly valuable in the presence of "chronic fatigue". It will, in most cases, help to overcome the depression and thus enable the patient to make a sincere and constructive effort to surmount his difficulties.

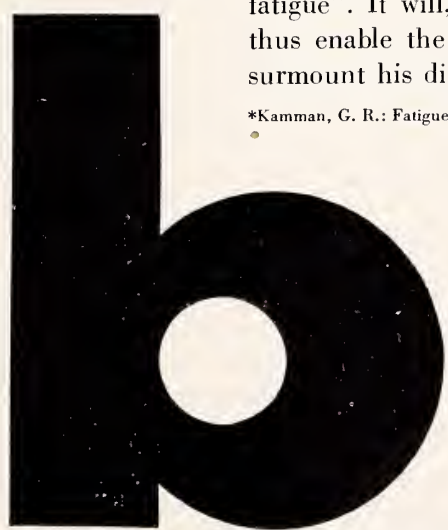
\*Kamman, G. R.: Fatigue as a Symptom in Depressed Patients, *Journal-Lancet* 65:238 (July) 1945.



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Labor spokesmen favored the state operated program while industrial representatives opposed it as being too costly and too likely to be dominated by politics and favoritism.

Industrial representatives centered their attacks on the Rhode Island and California publicly administered programs. California's law becomes operative December 1 and has an optional feature which permits insuring through private companies. The speakers said that already the CIO in California is urging that workers obtain the better protection of the private companies rather than the State operated plan.

Rhode Island's program was declared to be on the verge of bankruptcy, one that encourages widespread malingering and the taking of vacations at the expense of the state fund during the summer. In the main the industrial spokesmen supported the commission's original proposal that the insurance be carried by private companies or employers acting as self-insurers.

### Complete Chest Survey Service Offered in New York Hospital

*The Nassau Medical News* credits the North Country Community Hospital of Glen Cove, New York, with developing the first complete chest survey service offered in Nassau County. This hospital is said to be a pioneer in this work in the United States. Chest x-rays are required of all personnel applying for employment, volunteer as well as paid. In addition the hospital is endeavoring to take x-ray films on all admissions. In the case of obstetric patients this is done before arrival. A fee of one dollar is charged the patient for this service. Only a few months ago a rule was passed that in all operative cases, except emergencies, x-ray of the chest

must be made and the results of the chest survey reported to the physician before operation is performed.

## NEWS

### *from County Associations*

#### Fairfield

The Fairfield County Medical Association will hold its annual meeting in the Stratfield Hotel, Bridgeport, on Tuesday, April 8. There will be a business meeting followed by a social hour, dinner and a speaker. We are happy to announce that our guest speaker will be Dr. Morris Fishbein, editor of *Journal of the American Medical Association*.

The members of the Bridgeport Medical Association held a most successful banquet in the Stratfield Hotel on January 14. At this meeting the new officers for the year were installed. Both the retiring president, George Garlick, and the new president, Charles W. Nichols, favored the assembled members with a few words. After an excellent dinner some very talented entertainment was enjoyed by those present. Joseph Watts had gone to Broadway to especially select the talent and his efforts were well rewarded by the applause afforded the performers. One of the largest crowds in the history of the Association attended and the showing portended an active year for the Association. Every one of the one hundred and forty-three present agreed that a good time was had by all.

The regular meeting in February was held at the University Club on Tuesday evening, February 4, and the speaker of the evening was S. W. Moore, associate professor of clinical surgery at Cornell University, who gave a very interesting talk on "Perforated Peptic Ulcer." Dr. Nichols, our new president, called the meeting to order and introduced Dr. Moore.

Dr. Nichols announced the new council of the Association at the annual banquet as follows: George B. Garlick, William H. Curley, B. L. Smykowski, Irving B. Akerson, Joseph F. Watts, J. Grady Booe, Daniel F. Keegan, Andrew McQueeney, James F. Walsh, Benjamin R. Reiter, Edward P. Kemp, Roger C. TerKuile, Maurice N. Levy, Edwin R. Connors and James D. Gold.

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At the regular meeting in February the following new members were admitted to the Association: A. Paul Buchanan, Benjamin Sherman, Irving S. Eschwitz, Michael Anton, Allen F. Delevet and Alfred V. Siege.

St. Vincent's Hospital staff held its annual organization banquet on Tuesday evening, January 28, at the Merry-Go-Round in Fairfield. Arthur Sekerak presided at the dinner, having succeeded James F. Walsh to the presidency of the staff. Other officers of the staff are Edward P. Kemp, vice-president, and Leonard DelVecchio, secretary-treasurer. The executive committee consists of the officers and B. L. Smykowski and Joseph Howard.

At the annual meeting of the Norwalk Medical Society held at the Shore and Country Club in October 1946 the following officers were elected: President, J. Donald Corridon of South Norwalk; Vice-President, Ralph D. Padula of South Norwalk; Treasurer, Thomas P. Cody of New Canaan; Secretary, Alan M. Ross of Darien.

The annual dinner and election of officers of the Stamford Medical Society was held on January 14 at Hugo's. Feature of the affair was a rousing champagne toast to the "new fathers" of 1946—by courtesy of the new fathers. The officers elected for 1947 are: C. Louis Fincke, president; Sol Friedberg, first vice-president; E. Cotton Rawls, second vice-president; Alfred J. Sette, secretary; Jay E. Starrett, treasurer. The vote for official bouncer was a three way tie. After due discussion it was deferred to a later meeting.

William M. Stahl of Danbury has been notified of his election as a member of the National Gastroenterological Association, nationally known medical organization devoted to the study and treatment of the stomach and intestines.

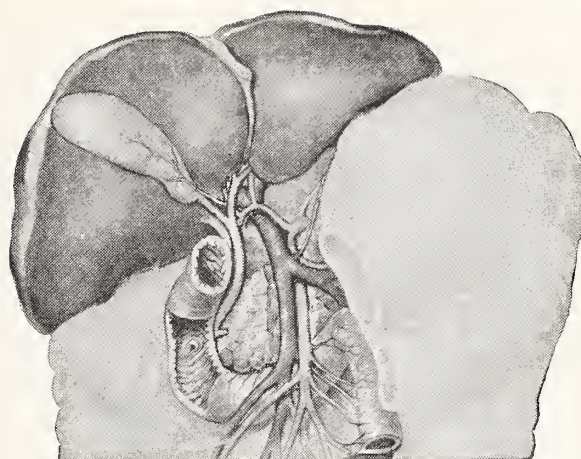
The annual convention of the Association will be held at Atlantic City, June 4, 5 and 6.

### Hartford

At the annual meeting of the medical staff of the Manchester Memorial Hospital, Manchester, David M. Caldwell was elected president, Edmund Zaglio vice-president, and A. B. Sundquist secretary.

Howard W. Brayton of Hartford was elected vice-president of the New England Pediatric Society at its annual meeting in Boston recently.

The Society held sessions of its annual clinical conference in the Children's Hospital, the Peter Bent Brigham and the Boston Floating Hospitals.



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ELKHART, INDIANA

William J. Watson has passed an examination qualifying him for membership on the American Board of Surgery.

Dr. Watson was notified by Dr. J. Stewart Rodman of Philadelphia, Pa., secretary of the American Board of Surgery, that he has met the standards of surgery as required by the board, first in qualifying for the examination and then in passing the tests.

The examination was taken by Dr. Watson in New York several weeks ago. He is the fifth New Britain surgeon admitted to membership on the American Board of Surgery.

During the war, he served in the navy with the rank of lieutenant commander and resumed practice here after his return from the service.

He has practiced in this city since January 1934 with the exception of the time he spent in military service. He is an attending surgeon on the staff of the New Britain General Hospital and is also a staff member and a director of the New Britain Memorial Hospital.

The many friends of Dr. R. Glen Urquhart will be pleased to learn that he has been appointed to the staff at St. Francis hospital, Hartford. He has been named consultant in diseases of the chest, the appointment being effective February 3.

Dr. Urquhart will prove a most valuable member of the staff since he is one of the outstanding men in the country in his line. In fact he is internationally known for his development of thoracic surgery in the treatment of pulmonary tuberculosis.

Dr. Urquhart has been engaged in private practice since his retirement a year ago as chief surgeon to the five state sanatoria. He was a member of the staff at Uncas-on-Thames for more than twenty years.

### New Haven

At a recent meeting of the staff of the Hospital of St. Raphael, Michael Shea of New Haven was elected president of the Medical Board. Dr. Shea, who was vice-president, succeeds Joseph D. Russo.

## ORTHOPEDIC SURGERY IN CONNECTICUT

THE JOURNAL OF THE CONNECTICUT STATE MEDICAL SOCIETY

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*written by DR. PAUL SWETT of Hartford*

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Edmund J. Behan was elected vice-president and Lloyd L. Maurer re-elected as secretary-treasurer.

Reports from the various committees of the board were heard, including a report on the outpatient clinic. William Collins, head of the clinic, reported that more than 1,200 visits had been made to date.

### **Windham**

All of Windham County, and the area about Putnam especially, were shocked at the unexpected death of Tony LaPalme. The notice of his death will appear in a subsequent issue. He was unusually young to be a victim of the "Doctor's Disease," yet old enough to be held established, respected and liked.

## **News from Yale University School of Medicine**

Eugene M. Blake, clinical professor of ophthalmology, was elected president of the New York Ophthalmological Society at the January meeting.

### **SCHEDULE OF THE PHARMACOLOGICAL SEMINARS FOR MARCH 1947**

March 6: Dr. Magnus I. Gregersen, Department of Physiology, College of Physicians and Surgeons, Columbia University

"Medical Science in Post War Poland"

March 13: Seminar sponsored by Dr. Albert S. Gray, Bureau of Industrial Hygiene, Connecticut  
Dr. Willard Machley, consultant in Industrial Medicine and Industrial Hygiene, New York

"Design of Experiments"

March 20: Seminar sponsored by Dr. Albert S. Gray;  
Dr. Harriet L. Hardy, Division of Occupational Hygiene, State of Massachusetts

"Pulmonary Disease in the Beryllium Industry"

### **Rheumatic Fever Follow-up at Yale**

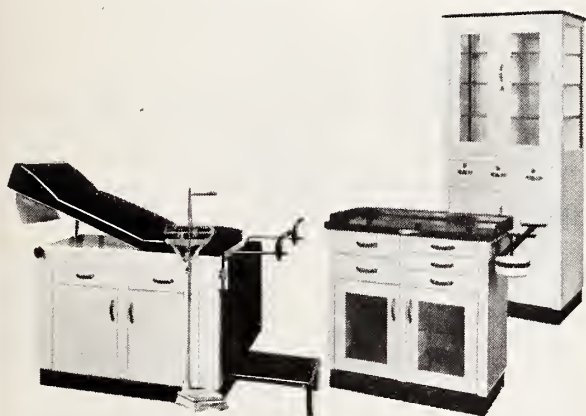
The Rheumatic Fever Study Unit of the Section of Preventive Medicine, Yale University School of Medicine, is conducting a 15-20 year follow-up study of one thousand cases of rheumatic heart disease and rheumatic fever which have occurred in patients who have been seen and whose records are on file at the New Haven Hospital and Dispensary. The examiner will be glad to communicate the re-



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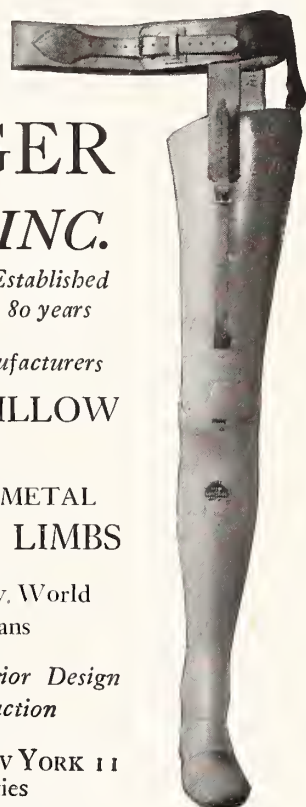
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sults of the examinations to the private physicians of these patients on written request to Dr. Jessamine Goerner, Section of Preventive Medicine, Yale University School of Medicine, 333 Cedar Street, New Haven, Connecticut.

Dr. Goerner will also be glad to communicate with physicians who wish to discuss other aspects of the follow-up study with her.

## NEW BOOKS IN REVIEW

*PERIPHERAL VASCULAR DISEASES.* By Edgar V. Allen, B.S., M.A., M.D., M.S., in Medicine, F.A.C.P., Division of Medicine, Mayo Clinic, Assoc. Prof. Medicine, Mayo Foundation, Graduate School, Univ. Minnesota; Diplomate of the American Board of Internal Medicine; and Nelson W. Barker, B.A., M.D., M.S. in Medicine, F.A.C.P., Division of Medicine, Mayo Clinic, Assoc. Prof. Medicine, Mayo Foundation, Graduate School, Univ. Minnesota; Diplomate of the American Board of Internal Medicine; and Edgar A. Hines, Jr., M.D., B.S., M.A., M.S. in Medicine, F.A.C.P., Division of Medicine, Mayo Clinic, Assoc. Prof. Medicine, Mayo Foundation, Graduate School, Univ. Minnesota; with Associates in the Mayo Clinic and Mayo Foundation. 871 pp. with 386 illustrations, 7 in color. Philadelphia and London: W. B. Saunders Company. 1946. \$10.00.

Reviewed by JOHN F. REED

When a group of experienced physicians, all actively engaged in the study and treatment of one disease group, publish their work in book form the result is almost sure to be a complete and excellent treatise. From the Mayo Clinic comes just such a collaboration in the above book. In the effort to be complete, however, sometimes the text becomes too long and the reviewer wonders if certain chapters, well covered in standard works elsewhere, could not have been omitted. Chapters on "Definition of Terms" and "Gross and Microscopic Anatomy of Peripheral Blood Vessels" would seem to be redundant and perhaps the chapter on "The Scalenus Anticus syndrome with and without Cervical Rib" might better be left to the neurological texts. A long chapter on "Nailfold Capillaries in Man" would seem to be a luxury to most physicians although the physiologist would find it interesting.

The above criticisms should not be taken too seriously. This is an excellent book and here one can find accepted methods of treatment for any of the peripheral vascular disorders from the esoteric scleroderma to the vulgar varicosities of the lower extremities. Chapter III on diagnosis is one of the best in the book and the table P195 illustrating the differential points in diagnosis between Reynaud's disease, Buerger's disease and arteriosclerosis obliterans will be of help to the perplexed clinician.

The controversial problem of whether to use anticoagulants

or to resort to surgery in cases of suspected or anticipated thrombi of the lower extremities is debated at some length. (The authors lean heavily toward the use of anticoagulants.) The reviewer was impressed by the apparent soundness of the reasoning regarding the indications for sympathectomy in vascular diseases inasmuch as the operation seem doomed to fall into disrepute if regarded as a "cure all" for many types of peripheral vascular disease.

The chart on P 662 regarding the contraindications to injection treatment of varicose veins with sclerosing solutions will be helpful on this sometimes perplexing problem.

The last 140 pages of the book are devoted to medical and surgical treatment and special technics. It is here that a splendid discussion will be found regarding the indications for and contraindications to anticoagulant therapy. Here, too, the book might have been shortened without harm to its content if specialized surgical procedures were left to the realm of books on surgical technique.

*SEX EDUCATION: A GUIDE FOR PARENTS, TEACHERS AND YOUTH LEADERS.* By Cyril Bibby, M.A., M.Sc., F.L.S., Education Officer to the Central Council of Health Education; Senior Lecturer at the College of St. Mark and St. John, London; sometime scholar of Queen's College, Cambridge. New York: Emerson Books, Inc. 1946. 311 pp. \$2.50.

Reviewed by LOUIS H. GOLD

A book on sex is difficult to write because so many people have different views on the subject and it is a hardship to please all of them. But here is a book that is written with such grace and good judgment that it should hold wide appeal. Mr. Bibby is an educator and he writes from the viewpoint of a teacher. He has enjoyed considerable experience as a student of sexual problems and his material is presented in an intelligent and highly acceptable manner.

Content is divided into eight chapters and six appendices. Their titles will give one an idea of the substance: the problems posed, the social setting, the parents' part, the school curriculum, sex problems in school, in the service of youth, in search of knowledge, educating educators, tentative scheme for sex education, suggestions for practical activities, sources of material and advice, specimen circulars and lectures, and guide to further reading.

The author believes the best place to develop a program of sex education is in the school. After reading his book everyone will agree with him. He speaks of a team consisting of a biologist with teaching and youth club experience, a physician with a knowledge of psychology and educational methods and a social worker. He discusses the usual difficulties surrounding the various problems concerned and approaches them in a practical yet idealistic manner. He shows that he has thought long and carefully about the entire subject and his wisdom reflects it.

This is a good book from beginning to end. It tells how to handle sexual problems that abound in the thought of children and young folks. It will appeal to parents, to school authorities, to the medical and allied professions, to all who are interested in public health and welfare.



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\**Laryngoscope*, Feb. 1935, Vol. XLV, No. 2, 149-154; *Laryngoscope*, Jan. 1937, Vol. XLVII, No. 1, 58-60; *Proc. Soc. Exp. Biol. and Med.*, 1934, 32, 241; *N. Y. State Journ. Med.*, Vol. 35, 6-1-35, No. 11, 590-592.



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# *The* CONNECTICUT STATE MEDICAL JOURNAL

VOL. XI

APRIL, 1947

No. 4

## 155th ANNUAL MEETING

The Connecticut State Medical Society

April 28, 29 and 30, 1947

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### PROGRAM COMMITTEE

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Monday, April 28, 1947

### ANNUAL MEETING OF THE HOUSE OF DELEGATES

NEW HAVEN MEDICAL ASSOCIATION BUILDING, 364 Whitney Avenue, New Haven

COLE B. GIBSON, *President, presiding*

10:00 A. M. GENERAL BUSINESS SESSION

1:00 P. M. LUNCHEON FOR MEMBERS OF THE HOUSE OF DELEGATES AND OFFICERS

2:00 P. M. THE MEETING RECONVENES—GENERAL BUSINESS AND ELECTION OF OFFICERS

### ANNUAL DINNER OF THE COUNCIL

NEW HAVEN LAWN CLUB, 193 Whitney Avenue, New Haven

7:00 P. M. ANNUAL DINNER OF THE COUNCIL, the Program Committee, the Local Committee on Arrangements and Guests

## GENERAL PROGRAM

HAMDEN HIGH SCHOOL, 2040 Dixwell Avenue, Hamden, APRIL 29 AND 30, 1947

Tuesday, April 29, 1947

COLE B. GIBSON, *President, presiding*

- 9:30 REGISTRATION
- 10:00 CALL TO ORDER  
WELCOME—President of the New Haven County Medical Association
- 10:10 MOTION PICTURE—The Effect of Drugs on the Heart in situ
- 10:30 PHYSIOLOGIC AND ANTIBIOTIC THERAPY IN BRONCHIAL ASTHMA  
Alvin L. Barach, *Presbyterian Hospital; Columbia University College of Physicians and Surgeons*
- 11:00 MANAGEMENT OF THE COMPLICATIONS OF DIABETES  
Elaine P. Ralli, *Bellevue Hospital; New York University College of Medicine*
- 11:30 INTERMISSION AND MOTION PICTURE—Sciatic Pain Caused by Ruptured Intervertebral Disc  
SAMUEL C. HARVEY, *presiding*
- 12:00 LESIONS OF THE ANTRUM OF THE STOMACH  
Richard Schatzki, *Massachusetts General Hospital; Harvard Medical School*
- 12:30 PRESENT STATUS OF THE MANAGEMENT OF THE RUPTURED INTERVERTEBRAL DISC  
Jason Mixer, *Massachusetts General Hospital; Harvard Medical School*
- 1:00 LUNCHEON—Cafeteria of the Hamden High School
- 2:15 SYMPOSIUM ON THE TREATMENT OF PERIPHERAL VASCULAR DISEASES

WILLIAM H. RESNIK, *presiding*

1. THE CONSERVATIVE TREATMENT OF PERIPHERAL ARTERIAL DISEASES  
A. Wilbur Duryee, *New York Postgraduate Hospital; Columbia University College of Physicians and Surgeons*
2. THE CONSERVATIVE TREATMENT OF THROMBO-EMBOLIC DISEASES  
Irving S. Wright, *New York Postgraduate Hospital; Columbia University College of Physicians and Surgeons*
3. THE SURGICAL TREATMENT OF VASCULAR DISEASES  
John Homans, *Boston Dispensary; Tufts College Medical School*

A round table discussion, with Dr. Wright as chairman, will follow the formal presentations. The audience will be invited to participate and it is asked that questions on any phase of the subject be sent, at least two weeks in advance of the meeting, to Dr. William H. Resnik, 65 South Street, Stamford

- 7:00 ANNUAL DINNER OF THE SOCIETY, NEW HAVEN LAWN CLUB  
Reservation cards for the Annual Dinner of the Society will be included in the formal program of the meeting



Wednesday, April 30, 1947

THOMAS P. MURDOCK, *presiding*

9:30 MOTION PICTURE—Myasthenia gravis

9:50 THE TREATMENT OF HYPERTENSION

1. END RESULTS AND INDICATIONS FOR THORACOLUMBAR SYMPATHECTOMY

J. William Hinton, *New York Postgraduate Hospital; Columbia University College of Physicians and Surgeons*

1. THE ROLE OF SODIUM RESTRICTION IN HYPERTENSION

George A. Perera, *Presbyterian Hospital; Columbia University College of Physicians and Surgeons*

10:30 THE DIAGNOSIS AND TREATMENT OF BRONCHIECTASIS

Herbert C. Maier, *Lenox Hill Hospital; Cornell University Medical College*

11:10 THE DIAGNOSIS AND TREATMENT OF CARCINOMA OF THE OESOPHAGUS

Richard H. Sweet, *Massachusetts General Hospital; Harvard Medical School*

11:40 INTERMISSION AND MOTION PICTURE—Purposeful Splinting of the Hand

CARL E. JOHNSON, *presiding*

12:00 THE CLINICAL SIGNIFICANCE OF CHANGES IN SMALL INTESTINAL FUNCTION

Franz J. Ingelfinger, *Evans Memorial Hospital; Boston University School of Medicine*

12:30 THE MANAGEMENT OF ACUTE CORONARY THROMBOSIS AND ITS COMPLICATIONS

Samuel A. Levine, *Peter Bent Brigham Hospital; Harvard Medical School*

1:00 LUNCHEON—Cafeteria of the Hamden High School

## CONVOCATION OF THE SOCIETY

THOMAS P. MURDOCK, *Chairman of the Council, presiding*

2:00 ADDRESS OF THE RETIRING PRESIDENT, Cole B. Gibson

Introduction of the President-Elect and the Officers for 1947-1948

3:15 SYMPOSIUM ON PSYCHONEUROSIS

ARTHUR H. JACKSON, *presiding*

1. UNDERLYING PHYSIOLOGICAL AND PSYCHOLOGICAL BASES

Jacob E. Finesinger, *Massachusetts General Hospital; Harvard Medical School*

2. CLINICAL EVALUATION

Benjamin V. White, *Hartford Hospital*

3. REMEDIAL MEASURES

Carl A. L. Binger, *New York Hospital; Cornell University Medical College*

## MEETINGS OF GUEST ORGANIZATIONS AND SECTIONS OF THE SOCIETY

Tuesday, April 29, 1947

## WOMAN'S AUXILIARY TO THE CONNECTICUT STATE MEDICAL SOCIETY

The Annual Meeting of the Woman's Auxiliary to the Society will be held on Tuesday, April 30, at the New Haven Country Club, Whitneyville, Connecticut, beginning with luncheon at 1:00 o'clock. The following program has been arranged:

1. SPREADING THE MESSAGE OF HEALTH TO THE PEOPLE  
Joseph I. Linde, *New Haven*
2. DANGER POINT—a sound motion picture
3. MORE LIFE FOR YOU—an American Medical Association broadcast script
4. BUSINESS MEETING

2:30 P. M.

## ANESTHESIOLOGY

1. PENTOTHAL, NITROUS OXIDE-OXYGEN, CURARE ANESTHESIA  
John G. Brody, *New Haven*
2. RESPIRATION  
Irvin Shaffer, *New Haven*
3. CASES PRESENTING INTERESTING ANESTHESIA PROBLEMS  
The resident staff in Anesthesiology, St. Francis Hospital, Hartford; under the direction of Stevens J. Martin

## DERMATOLOGY AND SYPHILOLOGY

MOTION PICTURE: Scabies (British Information Services production)

## INDUSTRIAL HEALTH

INDUSTRIAL NOISE AS IT AFFECTS THE EAR (illustrated)  
Willard F. Machle, *New York City*

## HEZEKIAH BEARDSLEY PEDIATRIC CLUB

PRACTICAL APPLICATIONS OF BASIC PROGRESS IN THE BLOOD DISORDERS (illustrated)  
Irving J. Wolman, *Philadelphia*

## NEUROLOGY AND PSYCHIATRY

PSYCHIATRY AND THE FUTURE OF MEDICINE  
Lawrence S. Kubie, *New York City*

## RADIOLOGY

PHOTOROENTGEN METERS AND THE CHARACTERISTICS OF COMMERCIAL X-RAY FILM (illustrated)  
Russell H. Morgan, *Baltimore*

## CONNECTICUT ASSOCIATION OF MEDICAL EXAMINERS

A PLAN FOR IMPROVING THE MEDICAL EXAMINER SYSTEM IN CONNECTICUT  
Alan R. Moritz, *Boston*



## SECTION MEETINGS

Wednesday, April 30, 1947

3:15 P. M.

### EAR, NOSE AND THROAT

1. THE SLIT LAMP  
Milton L. Berliner, *New York City*
2. SELECTION OF CASES FOR THE FENESTRATION OPERATION (illustrated)  
Philip E. Meltzer, *Boston*

### OBSTETRICS AND GYNECOLOGY

Program not ready for publication

### ORTHOPEDIC SURGERY

Program not ready for publication

### PHYSICAL THERAPY

Program not ready for publication

### SURGERY

#### SYMPOSIUM ON ULCERATIVE COLITIS

Donald B. Wells, *presiding*

1. MEDICAL ASPECTS  
Thomas T. Mackje, *Winston-Salem, N. C.*
2. ROENTGENOLOGICAL DISCUSSION  
Robert E. Pound, *New York City*
3. PATHOLOGY  
Walter W. Brandes, *New York City*
4. SURGERY  
Henry W. Cave, *New York City*

A motion picture and lantern slides will be shown

### TECHNICAL EXHIBITS

Technical exhibits have been arranged with Mr. Frank L. McDonnell, of E. L. Washburn and Company, Inc., and the following exhibitors:

H. J. Heinz Company, Pittsburgh  
E. R. Squibb and Sons, New York  
L. & B. Reiner, New York  
Spencer, Incorporated, New Haven  
Nestle's Milk Products, Inc., New York  
E. L. Washburn & Co., Inc., New Haven  
Brewer and Company, Inc., Worcester  
Van Pelt and Brown, Inc., Richmond  
Lederle Laboratories, New York  
C. V. Mosby Company, St. Louis

Professional Equipment Company, New Haven  
D. G. Stoughton Co., Hartford  
White Laboratories, Inc., Newark  
Doho Chemical Corporation, New York  
Surgeons & Physicians Supply Co., Boston  
E. F. Mahady Company, Boston  
Reed and Carnrick, Jersey City  
Philip Morris & Co., Ltd., Inc., New York  
Burroughs Wellcome & Co. (U. S. A.) Inc., New York  
Wm. P. Poythress and Co., Inc., Richmond

Mead Johnson and Company, Evansville

## THE OPERATION OF PUBLIC LAW 725

### The Hospital Survey and Construction Act

HERMAN E. HILLEBOE, M.D., *Washington, D. C.*

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The Author. *Assistant Surgeon General, United States Public Health Service*

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TO THOSE of us in the health and medical profession, the signing of the Hospital Survey and Construction Act was an event of great significance. It meant that American medicine, engaged in the fight to bring good health and medical care to all the people, would be better equipped with the hospitals and health centers needed to do the job. You in this audience have long been aware of our shortage of health facilities. That this shortage is clearly recognized by the States is evident from the action they have taken since the passage of this legislation. In less than six months thirty-three States have applied for Federal funds to conduct surveys of hospital facilities. Many of the States have already passed legislation relating to the program, while most of the others are presenting hospital bills of some type in their current legislative sessions. We can appreciate the importance of this action when we realize that the 375 million dollar Federal grant must be met by the States on a two-to-one basis.

The history of the Hospital Survey and Construction Act is a striking example of the power of concerted action in a democratic Nation. In 1943 the American Hospital Association resolved to seek Federal aid in building needed hospitals. This was the first of many spontaneous efforts that resulted in the introduction of Senate Bill 191, under the sponsorship of Senator Lister Hill of Alabama and Senator Harold Burton of Ohio.

During Congressional hearings on the bill, many professional and citizen groups came forward to support it. The American Hospital Association, the Catholic Hospital Association, and the Protestant Hospital Association joined forces with major farm and labor organizations, organized medicine, dentistry and nursing, to advance this legislation.

Many other groups and individuals of national importance also helped. The Bill became Public Law 725 when it was signed by the President on August 13, 1946.

Under the Hospital Survey and Construction Act the United States will be engaged in the most comprehensive hospital program ever undertaken by any nation. The broad purpose of the legislation is to assist States in planning for and providing hospital and health centers distributed geographically in proportion to need. We are all aware of the uneven distribution of health facilities in the United States. In spite of the real progress that has been made in raising the standards of health in our Nation, there are still many serious gaps. American medical care at its best is the finest in the world, but there are many areas of our country, many groups of our citizens, to whom the best is not available. We find the best equipped and most abundant facilities concentrated in the wealthiest States and in metropolitan areas, and the least adequate facilities in rural and economically distressed areas. In approximately 40 per cent of the Nation's 3,000 counties, representing 15,000,000 people, there are no registered hospitals. Many of the hospitals that are registered today fall far below standards that could and should be achieved. The lack of public health facilities is equally disturbing. Approximately 40 per cent of the counties have no full time public health services. And altogether too many of the others have so-called public health centers housed in cellars or court-houses, in condemned buildings, and in other undesirable locations. Not only are these centers badly located; they are so poorly equipped, for the most part, that instead of helping, they handicap public health officers.

As its name implies, the Hospital Survey and Construction Act has two main purposes: First, it provides assistance to the States in surveying over-all State needs and in making master plans for needed

*Presented at the National Conference on Medical Service, Chicago, February 9, 1947*



hospitals and health facilities. Second, it provides assistance for the next five years in the construction necessary to carry out these plans.

To accomplish this twofold aim, the Act authorizes an initial Federal appropriation of \$3,000,000 to assist with the surveys, and then \$75,000,000 annually for the five year period, starting July 1, 1946, to assist with construction. To date, \$2,350,000 has been made available for the survey and planning phase of the program.

It will be the responsibility of the present Congress to make the initial appropriation for construction. In view of the time needed for the survey and planning, it was not expected that the full \$75,000,000 authorized for construction the first fiscal year could be utilized by June 30, 1948. Therefore, construction appropriation of \$50,000,000 has been requested for the first year and approximately 100,000,000 will be asked for the second year.

Under the program, hospitals, public health centers, and related facilities may be constructed. By "hospitals" are meant general, tuberculosis, mental, chronic disease, and other types, but not those that furnish primarily domiciliary care. Funds for construction may be granted only to public and non-profit hospitals. Proprietary hospitals are excluded. A "public health center" is defined as a publicly owned facility for providing public health services, the scope of which is a matter of State law. "Related facilities" include laboratories, outpatient departments, nurses' homes, training facilities, and clinics.

The term "construction" is broadly defined to include: construction of new buildings; expansion, remodeling, and alteration of existing buildings; and initial equipment for any such new or existing facilities.

It should be emphasized that the Hospital Survey and Construction Act does not follow the pattern of the usual Federal works program. It is solely a grant-in-aid program. It delegates the major of responsibility to the individual State. A single agency of the State government will administer each phase of the program, and a State Advisory Council, composed of technical and consumer representatives, will participate actively.

Federal administration of the program is the responsibility of the Surgeon General of the U. S. Public Health Service, assisted by the Federal Hospital Council and its advisory committee. The Council consists of eight members, four of them outstanding in hospital and health activities, and four

representing consumers of hospital services.

One of the primary responsibilities of the Federal Administration is the formulation of regulations. The Act authorized the Surgeon General, with the approval of the Federal Hospital Council and the Federal Security Administrator, to establish these general regulations within six months after the signing of the Act. The regulations have been prepared and will soon be available. They cover such matters as size, distribution, and types of hospitals that may be constructed, construction standards, services for all persons regardless of race, creed or color, and service for those unable to pay. The regulations also set up methods of determining priority of projects to assure that hospitals will be built on the basis of relative need.

Within the United States Public Health Service, the responsibility for assisting the Surgeon General in the administration of the Act rests with the newly created Division of Hospital Facilities. The four major offices in this division are the Office of Program Planning, the Office of Program Operations, the Office of Technical Services and the Office of Hospital Services.

The Office of Program Planning develops general methods of improving hospital and health standards, and conducts orientation programs for Public Health Service personnel and for personnel of State agencies.

The Office of Program Operations formulates, interprets, and carries out regulations and procedures, analyzes applications for funds, and serves as liaison with the field through District Offices of the United States Public Health Service.

The Office of Technical Services develops standards and plans covering the architectural phase of construction, and reviews designs, blueprints, and construction details submitted by applicants.

The Office of Hospital Services develops standards and plans covering administrative phases of hospital services, maintenance and operation.

In order to insure a decentralized approach to this program, the Division of Hospital Facilities works largely through the District Offices of the United States Public Health Service. Personnel with specialized training will be assigned to each District Office and will include hospital consultants, hospital architects, construction engineers, and hospital administrators. The staff of the District Office will in turn work closely with State agencies, communities and organizations on every phase of the program. Application for survey and planning funds

and for individual construction projects will all be handled by the District Offices.

The Public Health Service in Washington is deluged with inquiries asking "How can we get a hospital in our town?" The answer to this question is embodied in the Act itself. To receive funds for survey and planning a State must designate an official agency to conduct the work, and must appoint an advisory council to assist this agency. The council must have some members who represent organizations or groups doing hospital work that are not part of Federal, State or local governments. The State then obtains an application for funds from its Public Health Service District Office—for Illinois it would be the Chicago office—and submits it to the Surgeon General. Upon approval each State is entitled to receive Federal aid for one-third of its survey and planning expenditures, provided, of course, that this amount falls within the State's allotment. These allotments for survey and planning are made to the States on a relative population basis. For example, it has been estimated that out of the three million for survey and planning, the allotment for Illinois would be \$172,752.

When a State has completed a comprehensive survey of all hospitals and related facilities, the next step is to draw up a master construction plan designed to meet the needs revealed by the survey. This plan, which must conform with the regulations issued by the Surgeon General, will be administered by the State agency. This may be the same State agency that conducted the survey or it may be a different agency appointed for the purpose.

The Surgeon General is authorized to approve any plan which fulfills these requirements. Should he disapprove a plan, the Federal Hospital Council must grant the State agency a hearing. If the Council decides that the plan complies with requirements, the Surgeon General must then accept the ruling of the Council.

Once the State construction plan is approved, the State enters upon the second phase of the program—the actual building of hospitals, health centers and related facilities. While survey funds are based on State population only, construction allotments are determined by a formula based on two factors—population and per capita income. This formula is weighted in such a way that States with low per capita incomes, where there is a relatively greater need for hospitals, receive more money per capita than do the wealthier States. Out of the first 75

million, the construction allotment for Illinois is estimated as \$2,771,175, whereas North Carolina, less populous State with a lower per capita income has an allotment of \$3,432,825.

To receive construction funds, the State, public or non profit group applies through its State agency to the U. S. Public Health Service. This project, of course, must have been included in the State construction plan. The application must contain plan and specifications for the proposed facility, assurance of financial support for construction, and for maintenance of the facility when completed. When this application has been approved, Federal funds to meet one-third of the construction costs may be granted. If the Public Health Service finds later that a State agency is not complying with the provision of the Act, or that funds have been diverted from the purpose for which they were allotted, payment may be withheld, provided that the State agency has been granted a hearing. In this case the project applicant may appeal to the United States Court of Appeals.

With this brief summary of the Act, you can readily see the problems that lie before us. Though all concerned regard this Act as a long step forward in health legislation, nevertheless, we should not overlook its limitations. Even when Federal funds have been matched by non Federal funds, totalling \$1,125,000,000 for the five year program, it will be possible to provide only about one-fourth of the Nation's needs for new and replacement health facilities. Even before the war, when building costs were 50 per cent less, the estimate for meeting these requirements was approximately \$4,000,000,000. It is obvious that the present funds, substantial as they are, can carry out only in part the purpose of the Act.

Another serious limitation is the formula for the distribution of Federal funds. All States, regardless of ability to pay, must meet Federal construction funds on a two to one ratio. Clearly, the need is greater in some States than in others. And in States where the need is most pressing, the per capita income is generally lower.

The limitations of this program do not attenuate the many significant and forward looking features. First among these is the requirement that each State survey its existing hospital and health facilities and developing a construction plan based on the survey. This procedure means that for the first time we are building our hospitals according to a long



ange plan. In the past they often cropped up here and there with little or no overall planning. In some areas there were too many; in most areas too few. Just after World War I, there was a boom in hospital building. By 1928, there were more hospitals registered in the United States than ever before or since. In the following ten years, several hundred went out of existence. The consequent tremendous loss in terms of money and potential services was probably due to lack of careful planning. The present Hospital Facilities and Construction Program provides real assurance that this will not happen again.

Another excellent feature is the requirement for minimum standards for hospital maintenance. All States must have a licensing law within two years after passage of the Act. In some States this will take the form of a model licensing act; in others these standards may be incorporated in general health legislation. In some States these standards will probably be high, while in others they will be barely adequate. Nevertheless, the philosophy behind this requirement is sound and should lead us to higher standards of hospital care.

Finally, I should like to emphasize once more one of the strongest principles embodied in the Act, namely the decentralization of this program. This

is not a Federally dominated program. It is a State program—a community program. The Federal role is largely one of guidance and assistance. To the State and the communities go the responsible task of carrying out the actual operation. Moreover, in its advisory phases the program requires both consumer and professional assistance. Just as the Public Health Service is required by law to have a Federal Hospital Council, so the State agencies administering the Act must have advisory councils to help them. These councils must be representative, not only of the medical and hospital fields, but also of the consumers of such services. In this way we achieve democratic community responsibility in the successful operation of the Act, for only if the community provides leadership and accepts full responsibility will the program succeed.

To you, as representatives of the medical profession, falls a good part of this responsibility. Your community looks to you to guard its health. It looks to you for help and guidance in its hospital planning, and it is to you also that we in the Public Health Service are looking for the cooperation and understanding that will be necessary if this program is to fulfill, even partially, the purpose that has been set for it—to provide the people of this country with the hospitals and health facilities needed to enjoy to the fullest the American way of life.

## MODERN INFLUENCES IN MEDICAL PRACTICE

THOMAS P. MURDOCK, M.D., *Meriden*

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The Author. *Chief of Staff, Meriden Hospital*

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THE SUBJECT "Modern Influences in Medical Practice" is timely. With the possible exception of the question of compulsory medical care, in my opinion, it is the most important subject confronting medicine at this time. Hand in hand with the subheadings which have been outlined for you goes the question of "Hospital Staff Organization."

There are many suggested plans for hospital staff organization, chief among these are the plans recom-

*resented at the National Conference on Medical Service, Chicago, February 9, 1947*

mended by the American College of Surgeons and the Commonwealth Foundation.

My suggested plan for hospital organization would be a board of directors elected from the corporators. The directors to select an executive committee. The directors to appoint a medical board made up of a chairman, vice-chairman, secretary and the chiefs of surgery, medicine, obstetrics and in the case of large hospitals the heads of other important departments.

The directors to name annually, upon the recommendation of the medical board, the active and con-

sulting staffs. Courtesy privileges shall be granted in the same manner.

The medical board shall also recommend the appointment of an intern committee, a program committee, a record committee and such other committees as are deemed necessary for the proper administration of the scientific work of the hospital.

Probably the most important of these committees is the program committee. This committee can do much to stimulate the interest of the staff and house officers with educational programs. A plan should include medical rounds, surgical rounds, weekly staff conferences, clinical pathological conferences and monthly staff meetings. The house officers should be given their proper places at all of these conferences. Educational programs are absolutely essential and the hospital that is careless in this regard cannot long survive as a hospital privileged to train interns.

The medical board shall recommend to the directors and aid the manager in the selection of such full time or part time physicians as are necessary for the proper administration of the scientific departments in the hospital. This refers particularly to the selection of radiologists and pathologists and anesthetists.

The question of the place of the general practitioner seems to be a controversial one at the present time. I feel that it is wholly a local matter and each hospital must judge this situation for itself. In small hospitals, and I would say in general, any hospital with one hundred beds or less could and probably should be manned by general practitioners.

A workable plan for smaller hospitals is to have the heads of the various departments certified. Larger hospitals, I believe, should stimulate all members of the staff to be certified or to become members of their special societies or colleges. However, hospitals deciding to require certification would be wise in not making the rule retroactive. Senior members of the staff not certified should be kept in their present positions. Newly appointed men to the junior staff should be given a period of five years in which to qualify for certification. I believe that some members of certifying boards feel that while it is desirable for staff men to be certified, its advisability will vary among hospitals, and should be decided by them.

Dr. Wingate Johnson, at the San Francisco session of the American Medical Association, read a splendid paper on the general practitioner which has been widely read. At the mid winter meeting of the

House of Delegates of the American Medical Association, Dr. Edwin Askey of California presented a resolution recommending that general practitioners be given their rightful places on hospital staffs. General Hugh Morgan at a recent meeting of the Board of Regents of the American College of Physicians made a strong plea for the better general practitioners. He felt that some place should be found for these men in the college.

I believe firmly that there will always be a place in American medicine for the general practitioner. It is my further belief that that place will always be close to the hearts of the men in medicine and to the hearts of all of the American people. The old French proverb "the irreplaceable man is yet to be" seems to fall down when one thinks of the general practitioner. No one can replace him.

Now still another controversial point in hospital organization is the appointment and election of members of the staff to the board of directors. The American College of Surgeons is opposed to the appointment of medical staff members to the board of directors.

The chief, and perhaps the only reason, is that favoritism will be shown these men so selected. I would like to go on record as being in total disagreement with this premise. Even if this were so in isolated cases, does this justify the indictment of all medical men? I think not. Does any one know of an industry or a banking institution wherein one or more executives are not on the board of directors? Again I think not. The College recommends that a liaison committee be appointed by the staff to meet occasionally with the directors. This, in my opinion, is not enough. At almost every meeting of boards of directors questions of medical administration and policy come up. With representatives immediately at hand, these questions can be decided at once. Good boards of directors hunger for the information and knowledge brought to them by members of the staff. Much good comes to the hospital, the board of directors and the staff by such close relationship.

And so in the changing order we find or at least think we find it necessary to make changes in our plans for hospital organization. The basic conditions remain the same. The first purpose being to give the very best medical care to all the people. The second purpose being vows of loyalty and industry by the members of medical staffs to the hospitals. It doesn't



make any great difference whether these purposes are made possible by certified men or good general practitioners. Medicine and hospitals will make the necessary changes as indicated after careful consid-

eration. They will be made slowly and carefully with the thought always before us that American medicine now leads the world in its care of the sick. We aim to keep it so.

## PRESENT STATUS OF STREPTOMYCIN IN THE TREATMENT OF TUBERCULOSIS

H. CORWIN HINSHAW, M.D., WILLIAM H. FELDMAN, D.V.M., M.SC., and MARJORIE PYLE, M.D.

H. Corwin Hinshaw, M.D., *Division of Medicine, Mayo Clinic*

William H. Feldman, D.V.M., M.Sc., *Division of Experimental Medicine, Mayo Foundation*

Marjorie Pyle, M.D., *Fellow in Medicine, Mayo Foundation, Rochester, Minnesota*

THE ULTIMATE place of antibiotics in the treatment of tuberculosis cannot be determined at this time. There is, however, increasing evidence that one of these substances, streptomycin, has a recognizable suppressive effect on some forms of the disease, while possessing a relatively low toxicity.

Streptomycin is derived from the soil-inhabiting fungus, *Actinomyces* (*Streptomyces*) *griseus*. The discovery of streptomycin was announced in January, 1944, by Schatz, Bugie and Waksman.<sup>1</sup> Soon afterward, Schatz and Waksman<sup>2</sup> reported the results of studies in vitro which indicated that streptomycin exerted a bacteriostatic and bactericidal effect on a human strain of *Mycobacterium tuberculosis*. Investigation of the antibiotic streptomycin was begun in April, 1944, by members of the staff of the Mayo Clinic and the Mayo Foundation for Medical Education and Research. Results of studies in vivo demonstrated a striking therapeutic action of the drug on tuberculosis produced experimentally in guinea pigs, with little or no demonstrable deleterious effect.<sup>3,4</sup>

The administration of streptomycin\* to human beings was begun cautiously, with concomitant

studies of the absorption, diffusion, excretion and toxicity of the drug.<sup>5</sup> Since the autumn of 1944 approximately one hundred patients who had various forms of tuberculosis have been treated with streptomycin at the Mayo Clinic for periods of one month to six months. Preliminary reports of the progress of this clinical investigation have been published.<sup>6,7</sup>

Streptomycin can be administered by intramuscular or subcutaneous routes, either continuously or intermittently. It can also be administered intrathecally by lumbar or cisternal puncture, and intrabronchially by means of nebulization. Oral administration is ineffective because of the negligible degree of absorption from the gastro-intestinal tract. Since the necessary period of treatment is relatively long in the presence of tuberculosis, intermittent intramuscular or deep subcutaneous injection is the method of choice. Determinations of the concentration of streptomycin in the blood indicate that an apparently satisfactory therapeutic level is maintained when injections are made at three, four, and perhaps six hour intervals, if the total daily dose is at least 1 gm.

The optimal dose of streptomycin has yet to be

*Presented before the meeting of the twenty-first Connecticut Clinical Congress, New Haven, September 11, 1946*

\*Streptomycin used for these studies was derived from several sources, largely from Merck and Company, Rahway, New Jersey and Abbott Laboratories, North Chicago, Illinois. Material also has been supplied by the Upjohn Company, Kalamazoo, Michigan and Eli Lilly Company, Indianapolis, Indiana. Since March 1, 1946, all supplies have been received through the Committee on Chemotherapeutics and Other Agents of the National Research Council, Dr. Chester S. Keefer, Chairman.

established. When parenteral administration is employed, we have considered 1 to 3 gm. administered in twenty-four hours to be satisfactory from a therapeutic standpoint, and we have found that administration of this dose and even larger amounts can be continued with safety for a period of several months. Intrathecally, we use a solution of 0.1 to 0.4 gm. of streptomycin dissolved in 1 to 10 c.c. of isotonic solution of sodium chloride or in cerebrospinal fluid. This amount is administered every twenty-four to forty-eight hours during the more acute stages of tuberculous meningitis. The usual dose of streptomycin administered by nebulization is 0.5 gm. per day. This amount is dissolved in 20 to 30 c.c. of isotonic solution of sodium chloride and the patient is instructed to nebulize a given amount at stated intervals (usually once an hour during the waking hours). The method of nebulization has been described by Dr. A. M. Olsen.<sup>8</sup> Streptomycin is relatively stable in solution; there is no demonstrable loss of potency when solutions of the drug are kept for several days at room temperature.

The optimal duration of treatment also is not yet known. Results of studies by Youmans and his associates<sup>9</sup> indicate that in the face of continued exposure to streptomycin, tubercle bacilli develop a marked resistance to the effects of the drug. Investigations to determine the clinical significance of this observation are being made.

The toxic potentialities of streptomycin constitute still another problem which is not entirely solved. To date, the most disquieting side reaction has been a disturbance of equilibrium, which has occurred in most patients who have taken the drug for any length of time, even when the dose has been limited to 1 gm. daily. This reaction seems to be caused by a neurotic effect on the vestibular component of the eighth cranial nerve or its end organ. It is presumed that streptomycin is the toxic agent, although the possibility that impurities in the preparation are responsible has not been eliminated. Results of repeated caloric stimulation tests reveal that gradual bilateral diminution of labyrinthine function occurs during treatment with streptomycin. Loss of function usually is nearly complete before the patient becomes ataxic and begins to complain of vertigo with change of position. Fortunately, compensatory mechanisms develop in the patient within a few weeks, and both vertigo and ataxia disappear, even though the administration of streptomycin is continued. Whether or not there is

any true recovery of labyrinthine function remains to be seen. Temporary nerve deafness has occurred in a few patients who have received large doses. This latter effect apparently is reversible, the hearing acuity returning within a few days after treatment has been discontinued.

Except for this unusual and apparently selective effect on the functions of the eighth nerve, streptomycin does not appear to cause serious toxic manifestations. Results of repeated studies of the blood have failed to show that the drug exerts any adverse effect on the hematopoietic system. In only one case has there been clinical and histopathologic evidence of renal damage. The patient, a victim of generalized miliary tuberculosis and tuberculous meningitis, received an average dose of nearly 5 gm. a day. In all other patients coming to necropsy there has been no evidence of toxicity in any of the organs.

Most patients receiving streptomycin complain of nothing except the discomfort of frequent injections. A few complain of malaise, headache, muscular aching and arthralgias. The more purified preparations of streptomycin recently made available are free of pyrogens. Certain earlier lots of the drug produced a histamine-like reaction. Toxic erythema and urticaria have occurred in several cases, but there have been no serious cutaneous manifestations. In a few cases, resumption of treatment after an interruption of one week or longer has caused a violent febrile reaction, apparently symptomatic of an acquired sensitization to streptomycin. In each case desensitization has been accomplished by the usual method of graduating the dosage.

Results of treatment with streptomycin must still be reported in the form of notes on progress. About a third of the patients treated thus far have had pulmonary tuberculosis. These patients elected to receive, and were selected for trial of, streptomycin therapy because in previous weeks or months their pulmonary disease had shown clinical and roentgenographic proof of activity and progression. These patients received streptomycin for periods of one month to six months. Approximately 80 per cent of the group exhibited a favorable response, that is, arrest of progression of their disease and evidence of a trend toward healing, while the condition of the remainder remained static, without further progression. Roentgenographic evidence of improvement usually has been noted in four to eight weeks; clinical improvement may begin earlier. Among several patients treated for the shorter periods, cessa-



tion of treatment was followed by exacerbation of the disease. In most of such cases resumption of treatment again effected a recognizable reversal of the disease process. Most patients who have pulmonary tuberculosis continue to improve after the administration of streptomycin is discontinued. Apparently, healing occurs by natural processes, which suggests that streptomycin has a suppressive action on the tubercle bacillus and in this way allows the natural defense mechanisms of the patient to gain the upper hand. As yet, no patient has had an extension of his pulmonary tuberculosis while receiving streptomycin. We should emphasize the fact that chemotherapy can be expected to be most effective against those recent pulmonary lesions which are disseminated by bronchiogenic and hematogenous pathways. The tissue changes of chronic, fibrocaseous tuberculosis constitute a mechanical barrier difficult, perhaps impossible, for any chemotherapeutic agent to surmount. Because of the potential toxicity of the drug, it is doubtful that streptomycin should be used in cases of minimal pulmonary tuberculosis or others in which the condition usually responds well to accepted methods of treatment.

Treatment of tuberculous empyema has not been successful when streptomycin is administered by intrapleural injections alone. In one case, parenteral therapy together with nebulization of streptomycin aerosol brought about prompt closure of an old bronchopleural fistula, and the small amount of residual pleural fluid did not produce tuberculosis when injected into guinea pigs.

In a small series—six patients—tuberculous lesions of the hypopharynx, larynx, trachea and bronchi have healed after a few weeks of treatment with streptomycin administered by nebulization. There have been no recurrences, to the date of this report, in this total group of six patients classified in this manner.

Three patients who had generalized miliary tuberculosis without meningitis have been treated with streptomycin. In each case there was clinical improvement and roentgenographic evidence of clearing of the pulmonary infiltration to a remarkable degree. All three patients, however, have died. Histopathologic studies revealed an unusual trend toward healing in all organs except the brain. Streptomycin apparently does not penetrate brain tissue, as shown by assays of organ extracts made post mortem.

Seven patients who had tuberculous meningitis have been treated with streptomycin. The first three received the drug by parenteral routes only, and although there was temporary improvement clinically and by laboratory criteria, the patients succumbed. The last four patients have received streptomycin parenterally for long periods and have also received it by intrathecal injection daily for two to six weeks at the beginning of treatment and again later, if symptoms of meningeal irritation happened to recur. These patients, treated thus, have lived for four to nine months at the time of this report. Their meningeal infection abated and possibly became quiescent, but there are residual neurologic signs.

Fourteen patients who had renal tuberculosis have received streptomycin for periods of two to twelve months. In nearly every case the urine has become, at least temporarily, free of acid-fast bacilli as shown by direct smear, and may remain free of them for several months after cessation of treatment. In two of these twelve cases the urine for several months has remained free of organisms as shown by the results of inoculation of guinea pigs, and it is possible that the renal tuberculosis may be arrested.

Three patients who had tuberculous peritonitis, one of whom also had tuberculous pericarditis, have been treated with streptomycin. The condition of two has shown a favorable response, but the prognosis is still uncertain.

Sinuses of tuberculous origin show regression during the period of treatment with streptomycin administered parenterally. The sinus often closes but there has been some tendency toward recurrence. Some types of cutaneous tuberculosis respond in a similar manner, with improvement in the patient's condition which frequently is only temporary.

The clinical trends observed have yielded considerable encouragement to the belief that streptomycin produces a recognizable retarding effect on the progress of tuberculous infection in man. If this is substantiated, streptomycin will become the first clinically feasible chemotherapeutic drug for use in human tuberculosis. Even though the drug has certain shortcomings and limitations, it may prove to be a deciding factor in the prognosis of certain types of tuberculosis in which the patient needs temporary assistance to his natural powers of defense against tuberculous infection.

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## COMMON ANAL AND RECTAL PROBLEMS

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IN THIS short paper I may not present anything new to many of you but may point out that sometimes physicians fail or neglect to give time enough to something that may seem trivial or a minor problem to the physician yet be of great concern to the patient.

Common anal or rectal problems that the general practitioner or surgeon is called upon to diagnose and treat are the everyday variety such as pruritus ani, hemorrhoids, polyp, fissure, fistula and rectal prolapse and to differentiate from cancer, colitis, tuberculosis, and lympho-pathia venerum. There are two outstanding symptoms which, when present, cause great anxiety in every patient's mind, namely: pain and bleeding. His question is, what causes the pain? Why should I have increasing or recurring discomfort? Blood from the rectum in any form is not natural and why should it be present? In this day of enlightenment and interest, the laity is becoming better informed through the radio and press and being warned of danger signals. Some have a dread of cancer and fear they will find out the truth. They try all the patent medicines and concoctions or follow the free advice of those who have had similar complaints. However, the anxious ones seek relief from their trusted medical advisor and this is

when the physician is put to the test of making a true diagnosis, a differential diagnosis from any of the other conditions which would cause the same symptoms. The majority of patients will say, "I believe I have piles or hemorrhoids because I have had pain in the rectum or blood in the stools." At this point some physicians make the sad mistake of accepting the patient's diagnosis or make a careless sort of an examination and prescribe suppositories or some well known pile ointment which the patient could have bought over the drug counter without a prescription. No reliable physician would accept a patient's diagnosis of tuberculosis because he had coughed up some blood, or malaria because he had a chill, or gall-stones or appendicitis because of pain in the abdomen, or pregnancy because menstruation is irregular or absent. No, he would use every possible agency at his command to determine the cause. He would use his power of sense and reason along with every available instrument such as x-ray, laboratory, and a careful physical examination. He would use his sense of sight and feeling as well as instrumentation.

*Pruritus Ani* or "itching piles," as it is often termed, is a most annoying condition. In many cases it causes restlessness or nervousness, loss of weight

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and insomnia and may terminate in an infection such as an abscess, fissure or fistula. The etiology is generally within the anus or rectum in such growths as polyp, papilla, or crypt or it may be caused by skin folds or tags, warts or external hemorrhoids on the skin surface. These are supplied by the sensory nerve endings and the secretion from the growth within causes the irritation. The cure in advanced or chronic cases is surgery. No oils or ointments should be administered. The area should be cleaned without the use of soap and the skin kept dry by dusting with corn starch or a bland talcum powder. Many times this effects a permanent cure. Therapeutic doses of x-ray may be used if a fungus infection is present.

*External or Thrombotic Hemorrhoids* present a surgical problem if a cure is to be obtained and if there are any internal or prolapsing hemorrhoids present these should be removed at the same time. Care should be taken to remove all skin tags, papillae, polypi, and fissures in order to leave a smooth surface and thus prevent future pruritis. It is most important to give regular postoperative care in the form of gentle dilatation for a period of two months to prevent granulation and stricture or narrowing of the canal.

*Simple Internal Hemorrhoids* without complications such as fissure, polyp, fistula, papillae, or marked prolapse, may be treated by injection. This may be preventative and in most cases a permanent cure can be effected if the cases are well selected. This ambulatory method is often best because there is no loss of time, no hospital expense, and no pain or discomfort. The most generally accepted drug is sclerosis, and the one that I have used exclusively without pain or infection, is one half c.c. of a 5 per cent solution of quinine and urea hydrochloride injected into the mucous membrane or pile-bearing area and not in or near the skin. External piles should never be injected.

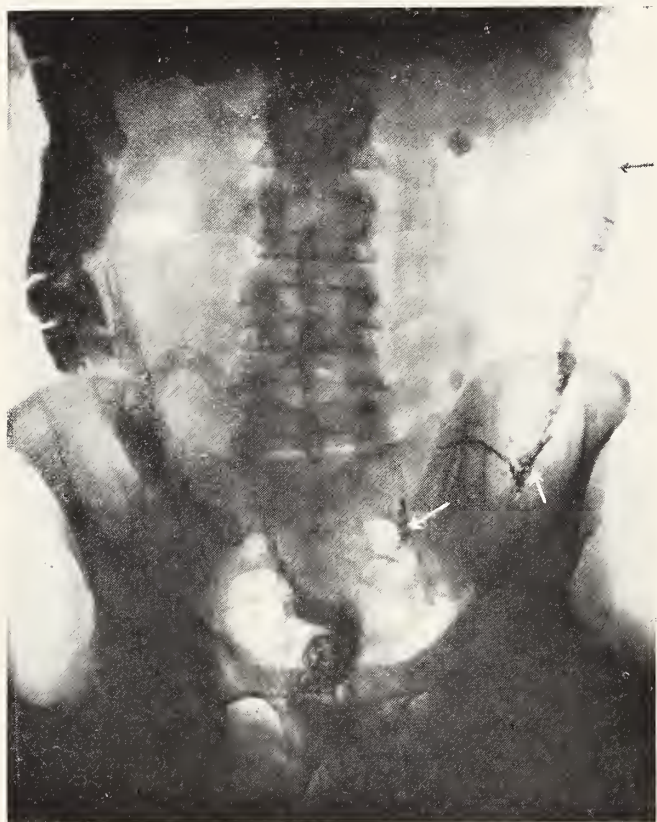
*Fistula* whether single or multiple, simple or complicated is usually caused by infection or tuberculosis. Formerly it was believed that 95 per cent of all fistulae were tubercular in origin. Experiment by inoculations have proved that this is not the case. Now the pendulum has swung in the opposite direction and most authorities believe that not more than 10 per cent are tubercular in origin and most of these may be found in tubercular hospitals or sanatoria. In a series of 5 cases of various types of fistula, many of which were of long-standing and compli-

cated, in patients at Laurel Heights Sanatorium who had very little resistance, radical excision of all tracts and involved tissue was done with 100 per cent cured and no recurrences. X-ray of the chest showed that there was or had been involvement of the lungs in all these cases and all had been incised many times previously.

*Constipation* is not a disease in itself. It is a symptom or habit growing out of carelessness or neglect. It seldom, if ever, occurs in animals where a call to nature is habitual. Ample exercise, regular diet and water cause normal evacuations. Men returning from service have told me that many times while traveling or in the line of duty they had to postpone the urge for long periods. Also nurses, stenographers and others in responsible positions who could not leave their posts have caused the habit to grow. Many cases of chronic appendicitis, gastric ulcers and intestinal irregularities can be cured by teaching the patient the necessity for regular elimination. However, it may be necessary to exclude any pathology by x-ray or sigmoidoscopic examination first. Three simple rules will cure any case of constipation if there is nothing organically wrong. These rules must be followed diligently and without interruption: (a) A regular time to go to the toilet daily, without a book or newspaper and to concentrate on the purpose for being there. (b) A glass of water every hour from the time of arising until supper, a total of fifteen glasses of water per day. (c) To start with, one half ounce of mineral oil before retiring until a regular habit is established and then it may be discontinued gradually. If these three rules are followed there will be no need for C.C. pills in the army, nor Carter's Little Liver Pills nor "Serutan for all those over 35."

To make a correct rectal examination one must take time and use all the agencies at his command. Osler once said, "A physical examination is never complete until a rectal examination has been done." Two senses are necessary; to be sure of what you see and to know what you feel. One must use the examining finger and then the eye through the instrument. Authorities such as Buie at the Mayo Clinic, Binkley at The Memorial Hospital and Jones of Cleveland state that 65 per cent of all tumors of the large bowel appear in the lower rectum and are within reach of the examining finger. A careful examination with the digital finger will detect most abnormal growths or pathology if present. Of course this should be verified by instrumental exam-

ination. The anoscope or rectoscope will afford direct vision of the field and any pathology can be verified or excluded. A most important thing for a good examination is to have a careful preparation of the patient. It is just as important to have a clean field for a rectal examination as for an x-ray examination. Unless there is a clean field, including the rectum and the sigmoid colon, some lesion or growth may not be seen. I prefer the knee-chest position for examination or, better still, the patient placed on the Haynes-Allison table, face downward with the head much lower than the hips. Not to use the examining



finger in the rectum often reflects on the physician's ability to make a correct diagnosis. Routine rectal examinations will detect many early growths and improve one's ability to diagnose without embarrassment. I make it a rule to do a procto-sigmoidoscopic examination on every patient over thirty, the age of approaching cancer, where there is a history of bleeding or a growth. If this examination does not reveal any suspicious abnormalities within reach of the scope, I advise an x-ray consultation. The cooperation and joint examination by the roentgenologists at the Bridgeport Hospital has been most gratifying and the results most satisfactory. Through the use of the proctoscope polypi, cancerous growths, colitis, a direct view of the lumen, the

color of the mucous membrane, and the presence of free blood or mucous in the tract can be determined. No treatment should be instituted until the possibility of cancer has been excluded. Every polyp, regardless of size or location, should be regarded as a potential cancer. To watch and wait may be too late. I want to go on record as advocating the early removal of any and all polypi. Whether it be done by excision, cauterization or fulgeration is elective. Ten years ago I excised by loop and electric cauterization a pedunculated polyp in the sigmoid of a patient who had been told to wait at several good clinics. He continued to have bleeding so I removed it. Recently I was informed that cancer had developed at the site of the removed polyp. There seems to be a predisposition in some individuals to develop polypi. A person may have a polyp in the nose or uterus and at some later date they appear in the rectum. Lockhart-Mummery pointed this out in his early writing and also stated that certain families seem to have a hereditary tendency toward cancer. He was also one of the first to call attention to the fact that rectal polypi had a tendency to become malignant.

Recently a well developed man, forty-nine years of age, weighing 180 pounds with no loss of weight but rather a tendency to gain, came to me for a rectal examination. He was anxious about himself because of his family history. His father had died a few years before of cancer of the throat, his mother of cancer of the rectum and three years ago a sister of cancer of the rectum. Recently a brother had an operation for an intestinal cancer. He also told me another sister had had an operation for multiple rectal polypi. He had experienced no change in bowel habit, no loose stools and no constipation but had on one occasion a slight tinge of blood in the stools. He had gone to a physician for a period of physical examination a short time previously, and the physician told him he could feel a small growth in the rectum and advised a complete rectal examination. I examined the man and a small polyp, about 5 cms. inside the rectum, could be felt with the examining finger. It was soft, about the size of a pea and not fixed. About one inch above this one was another, a little larger, and this one felt suspicious and made me suspect that it might be undergoing malignant change. I passed the anoscope and could see these growths. Then the proctoscope was introduced with direct illumination on the field and three other, smaller ones could be seen. None of the other



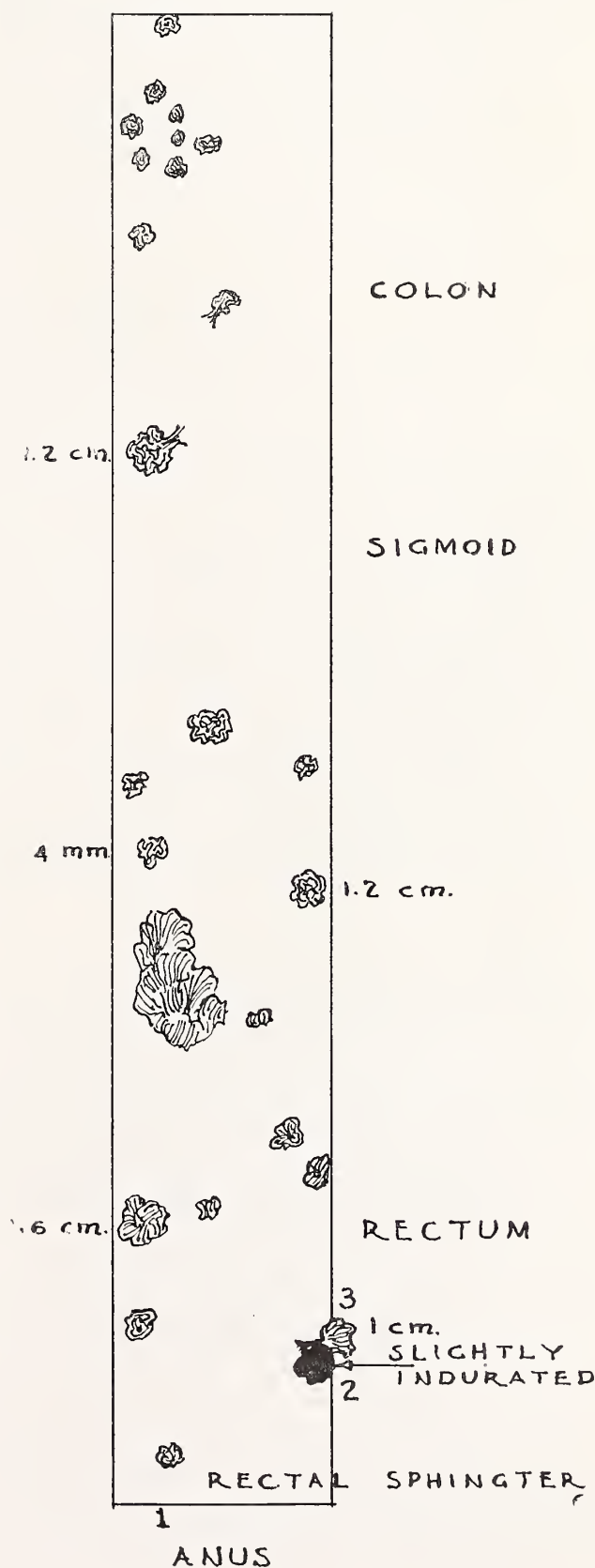
ever larger than a small pea but I told him what I had found and advised him to enter the hospital for biopsy, x-ray and further study. He was prepared and examined by a surgeon and me and the small polypi were noted in the rectum. We took biopsies of the lower one and the suspicious one. Later the same day I was called to the hospital by the intern to see the patient who was having a severe hemorrhage from the site where the biopsies were taken. He was taken to the examining room and re-proctoscoped and all the clots and free blood was removed. It took one hour but during the struggle I found two other small polypi that we had not seen before. An x-ray taken at the hospital two days after the hemorrhage showed multiple polypi throughout the sigmoid and colon. The pathological report of the suspicious polyp was adeno-carcinoma. In view of these findings of the x-ray and the pathologist, and the multiple polypi throughout the rectum and sigmoid, we advised a radical operation.

We did a one stage abdomino-perineal operation removing the anus, rectum, and the sigmoid colon to the extent of about 49 cms. There were no palpable glands nor polypi in the other parts of the intestinal tract. The liver, spleen and gall bladder appeared to be normal. He made a splendid recovery and was discharged from the hospital after three weeks in good condition. This patient will be sigmoidoscoped and re-x-rayed at regular intervals to detect any recurrence of these polypi.

The pathologist at the Bridgeport Hospital made a minute and detailed study of the entire specimen removed. I am indebted to him for this chart. We were much surprised, when the specimen was dissected, to find a total of 21 polypi throughout its length. None of them were very large nor did they seem to have invaded the muscularis. They ranged in size from a buckshot to a large pea and only the one mentioned above was malignant. The pathologist numbered and sectioned each one separately and gave a detailed written report of each growth.

Statistics from clinics such as The Mayo Foundation and The Memorial in New York show that there is a certainty that about 10 per cent of all polypi of the rectum and colon change from a benign to a malignant state. A definite reason for this transformation has not been established. I do not believe these polypi degenerate. I believe that they transform into a malignant state. Also, according to reliable statistics gathered at various hospitals and clinics the agreement is that a fair average of all patients who survive a five year period after an

operation for cancer of the rectum is not more than 10 per cent. Then, if one out of every ten rectal polypi transform into cancer, my reasoning and contention is that if all rectal polypi are irradiated



early, the number of cases of cancer of the rectum will decrease in the same proportion.

#### SUMMARY

(1) A thorough and complete study of all cases of rectal disease and the use of all agencies available to make a complete diagnosis. Impress on all patients the importance of early treatment.

(2) A procto-sigmoidoscopic examination should be done accurately and under good preparation.

(3) X-ray should be the agent used in diagnosing pathology of the upper intestinal tract coupled with the clinical findings.

(4) All specimens should be examined by the pathologist and his report will help greatly in determining the course of treatment.

(5) All polypi should be considered potential cancers and treated accordingly to prevent the occurrence of malignancy as much as possible.

## THE CLINICAL USE OF FLUORESCEIN

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LANGE and Wolheim<sup>1</sup> in 1931 showed that fluorescein when injected intravenously emitted a fluorescence which could be seen in the living tissue. In 1942, Lange, Herrlin, and Glasser<sup>2</sup> reported the clinical use of the dye in cases of strangulated hernias. Since that time, work has been published showing its application in skin grafting,<sup>3</sup> therapy and course of myxedema<sup>4</sup> and circulation time.<sup>5</sup> At present, investigation is in progress which indicates this dye may be accurate index of glomerular function.<sup>6</sup>

#### PROPERTIES

Fluorescein,<sup>1</sup> an inexpensive form of resorcinophthalein, is an extremely defusible dye which absorbs ultra violet rays of long wave length. When ultra violet rays of 3,660 angstrom units strike fluorescein they are instantly converted to waves which are interpreted by the eye as a greenish golden glow. A commonly used preparation consists of 5 per cent fluorescein containing 5 per cent sodium bicarbonate. This is available in prepared, relatively inexpensive ampoules, and appears to be entirely innocuous to the mammalian body. The only untoward effect ever noticed has been a momentary nausea which is fleeting. The dye is excreted unaltered in the urine.

When injected directly into the circulatory system, fluorescein is carried by the blood to every tissue which is bathed by the circulatory media. The

dye diffuses into the tissues and the degree of fluorescence of any given part is proportional to the degree of capillary permeability.

Thus in areas of complete ischemia there will be no demonstrable fluorescence, while in states of increased capillary permeability, as myxedema, the degree of fluorescence will be proportionately increased. The visibility of this fluorescence depends of course, on the type of tissue and the amount of pigment present. Thus it is seen well in the skin of a white person and poorly in a negro, while the mucous membranes and serous surfaces of both fluoresce equally well. A definite dosage must be decided upon in order that standards can be established.

The accuracy of reported work with this dye and its apparent value as an informative procedure led us to investigate the possibility of its being of value in the clinical work ordinarily carried on in a general hospital. While elaborate methods with costly equipment were frequently used in research, we were interested in its applicability without costly apparatus and added personnel. It was not found necessary to use specially constructed darkened rooms as the drawing of ordinary dark shades in operating rooms and wards proved satisfactory. Our entire equipment consisted of an ultra-violet light with a Wood's type filter which excludes nearly all the visible and erythema producing light. This is

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all the apparatus used by us for circulatory time and circulatory status to the extremities and costs less than \$40. The following represents our experiences under these conditions.

#### SURGICAL APPLICATION

*Bowel*—In 1942, it was shown that strangulated bowel and/or omentum could be separated from healthy tissue by this method. Every surgeon knows the difficulty encountered in deciding whether such issues need resecting, and realizes the gravity of this decision. Under the filtered ultra-violet light, normal bowel gives off a greenish golden glow, while strangulated bowel has an even deep purple color. This is a very simple procedure and does not endanger the sepsis or retard the speed of the surgical operation. The dye is injected, the room darkened and the filtered ultra-violet source is focused onto the tissue in question from behind the surgeon. Other investigators<sup>7</sup> have found that if fluorescence occurs, in the affected loops, within twenty minutes the issue is viable and need not be resected. There have been three occasions in this general hospital for application of this principle.

One of our cases showed non-fluorescence of over five feet of ileum whereupon this segment was resected. Pathological study proved it to be gangrenous. The other two questionable cases showed a delayed but positive fluorescence and conservative therapy was adopted with perfected recovery of the patient. It is interesting to note that the usual signs of viability, such as return of color and pulsation of vessels, were not satisfactory in these latter two cases.

*Emboli*—A 69 year old housewife was admitted to this hospital November 4, 1945 with a history of sharp sudden pain in her left leg two hours prior to admission. On admission the patient was found to be fibrillating rapidly and excruciating pain was still present in her left leg. The extremity was cold, tender and cyanotic, but without sufficient signs of demarcation to be certain of the probable location of the embolus. 8 cc. of fluorescein was injected intravenously and no fluorescence was seen below the knee of the affected leg. Above the knee there was a patchy type of fluorescence, also present over the entire right extremity. This patchy type of fluorescence is indicative of arteriosclerosis. The circulation time from arm to lip was 26 seconds, indicating cardiac failure. Thus it was learned that there was a clot in the popliteal space, probably at the bifurcation, this localization later proven by microscopic

study. It was also demonstrated that she was in cardiac failure and was arteriosclerotic.

An 84 year old male was admitted with a similar history of sudden pain in his right leg followed by coldness and cyanosis of that extremity. There was no fluorescence seen below the popliteal space and the section of the artery and microscopic section proved a thrombosis at the bifurcation.

*Plastic Surgery*—Fluorescence has been shown to be of value in determining the vascularity of tissue beds prior to grafting. If the base and margin of the defect show poor fluorescence, then the graft will not take as the circulation is inadequate, and appropriate preparation of the bed is indicated. There have been at least 15 such cases wherein fluorescence was of value. A twenty-seven year old white female was admitted with second and third degree chemical burns of the flexor surface of the right forearm. When it was decided to graft this area, 8 cc. of fluorescein were injected and a 14 x 5 cm. area on the flexor surface of the right forearm representing nearly the entire burned area showed no fluorescence. The skin surrounding this area showed an adequate fluorescence. Debridement of this area to tissue with good fluorescence produced a 100 per cent take of the graft. In cases of tubular grafts, fluorescein has proven of value in determining whether adequate circulation has been established. In transplants, injection of this dye serves as a good prognostic method, since poor fluorescence means poor circulation which is indicative of a poor prognosis. We have used this test with gratifying results in two cases of tubular grafts.

*Amputations*—Fluorescein was found to be effective in selecting sites of amputation. A 26 year old, recently discharged marine was admitted to this hospital approximately one hour after having his hand, forearm and arm caught between rollers. On admission the fingers were crushed, the radial vessels and axillary arteries appeared severed, and the forearm and arm were severely contused, cyanotic and cold. It appeared that a radical amputation of the arm including the scapula was the procedure of choice. Because of the age of the patient, it was decided to attempt conservative methods in place of immediate amputation, and fluorescein was used in an effort to determine what tissues might prove viable. Fluorescein was injected and adequate fluorescence was seen over the entire arm with the exception of a 4 cm. area on the posterior aspect, the forearm being non-fluorescent. It was decided to

postpone amputation until the following day when another fluorescein study showed the same result. A midarm amputation was done. The area of poor fluorescence on the posterior surface was just over a portion of coracobrachialis which appeared to be ischemic. This was removed and the stump healed perfectly in the usual period of time with the salvage of a normally functioning shoulder which might otherwise have been sacrificed.

At this institution there have been several cases of gangrenous toes with diabetic endarteriosclerotic etiology. In these cases, it was important to know where the site of the amputation might be for a healing stump. Fluorescein has proved of value in these cases.

#### MEDICAL

*Circulation Time*—The physician who limits his practice to internal medicine will find a multitude of uses for this dye. Fluorescein serves as an ideal method of determining circulation time. While subjective methods are dependent upon variations in sensory thresholds of the patient,<sup>4</sup> fluorescein is objective, nontoxic and can be successfully used on children and unconscious patients. There is no costly equipment needed such as with the CO<sub>2</sub> method and others. One watches for the greenish golden glow to reach the lips and if several people are observing all will see the dye within a second of each other as the end point is sharply defined. The dye (1.3 cc. per kg. of body weight) is injected rapidly in a vein in the ante cubital space and the observer watches for the appearance of this greenish golden glow to the lips. Patients must be under basal conditions as exercise, anemia below three and one half million red cells and hyperthyroidism increase the rate of blood flow. The normal arm to lip time is between 15 and 17 seconds.<sup>4</sup> Thus the method may be used to differentiate between hyper and hypothyroidism, since in hyperthyroidism without cardiac failure the rate is increased while in hypothyroidism the circulation time is increased. In cardiac asthma the circulation time is increased while in bronchial asthma there is no increase.<sup>1</sup> We have used this method at least two dozen times to determine cardiac status with results that have been compatible with clinical and other laboratory findings.

A report by Nathanson<sup>5</sup> suggesting the use of wheals produced by an intradermal injection of histamine makes it possible to accurately determine circulation times to any part of the skin surface. We

have found this addition to fluorescein methods to be accurate and valuable in selected cases.

*Disturbances in Capillary Permeability*—In conditions where there is an increase of capillary permeability such as myxedema, lipoid nephrosis and in the chronic stage of nephritis, a great increase in the amount of fluorescence is reported.<sup>4</sup> Our only experience with such a condition was a case of lipoid nephrosis where an intense fluorescence was noted. The degree of fluorescence serves as a good index of the course of the disease. With improvement the thyroid deficient patient and the patient with renal pathology shows a gradual decrease in the intensity of the fluorescence.

*Kidney Function*—It has been proven with aglomerular fish<sup>6</sup> that fluorescein is secreted entirely by the glomeruli. The urine content of fluorescein is believed to be a good index of kidney efficiency. Standards are prepared and the urine is collected every thirty minutes for two hours and the amount of fluorescein in each sample is determined. It is said that the normal kidney excretes at least 33 per cent of the fluorescein in the first hour. We have compared the excretion of phenolsulfonphthalein with fluorescein and find an agreement in the curve of the two, but as yet we are not certain of its accuracy and have reached no definite conclusions as to its value.

#### MISCELLANEOUS

The possibilities for the use of fluorescein seem unlimited. Recently, there have been two cases of acute renal retention in this hospital. One patient was a 29 year old unmarried white female with a negative past history. Approximately ten days before admission she had what she believed to be an upper respiratory infection. Small doses of sulfadiazene were given but the patient did not respond. Her urine output became progressively less, and her N.P.N. reached 160 mg. per cent with a creatinine of 5.7 mg. per cent. The patient appeared to be moribund. It was decided to decapsulate the kidney. Fluorescein was injected and, on removal of the capsule, there was diffuse and adequate fluorescence which was interpreted as sufficient circulation to the cortex and therefore indicative of a good prognosis. This patient recovered. Two months later a 43 year old, well nourished, well developed male was admitted with a similar history except that no sulfa was given. His N.P.N. reached 170 mg. per cent with a creatinine of 7 mg. per cent. The de-



capsulated kidney showed no fluorescence and the urine showed no fluorescein. Since fluorescein is excreted by the glomeruli, it was interpreted that there was parenchymal kidney pathology and therefore the prognosis was poor. This patient expired three days later and permission for autopsy was refused. These two cases show how the circulatory status of tissue may serve as a valuable prognostic method.

#### CONCLUSIONS

On the basis of our experience with intravenous fluorescein in a 500 bed general hospital, using inexpensive and simple equipment, we believe that fluorescein has been of value in determining circulation time, prognosis of grafts and ulcerations, site of amputation and circulatory status of limbs in peripheral vascular disease. As in all such procedures the interpretation must be based on a lucid understanding and integration of the clinical signs and

laboratory data. We recommend it as a simple, inexpensive procedure which can be used in any general hospital.

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## SOFT TISSUE SARCOMA—TEN YEAR SURVIVAL FOLLOWING ROENTGEN RAY THERAPY

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ALTHOUGH sarcomas of the soft tissues are infrequent, a few reports of relatively large series of cases have appeared. Bick<sup>1</sup> collected twenty in one series, and 42 in another.<sup>2</sup> French<sup>3</sup> published a review of 16 cases, Stewart and Copeland<sup>4</sup> summarized 64, Quick and Cutler<sup>5</sup> analyzed 72, and Kaplan and Rubenfeld<sup>6</sup> discussed 78 cases.

#### ETIOLOGY

Trauma as an important etiological factor in the development of soft tissue sarcoma has been emphasized by many. Coley<sup>7</sup> as early as 1898 reported 170 cases of sarcoma, of which 46, or 27 per cent, gave a history of trauma. In nine of these, the tumor developed within one week following injury. Again Coley<sup>8</sup> in 1910 reported 800 cases of sarcoma of which 179 had a definite history of trauma. Fourteen of the 72 cases in Quick and Cutler's series had a history of antecedent trauma. In the final analysis the determination of the role played by trauma in the genesis of soft tissue sarcoma is most difficult.

In some instances the association between the two is extremely remote, while in other instances it is only suggestive.

#### AGE

It has been repeatedly stated that sarcoma occurs most commonly in youth or young adulthood. Actually an analysis of the collected groups cited above shows a very wide age span. Forty-four or 56 per cent of the cases of sarcoma of soft tissue reported by Kaplan and Rubenfeld appeared during the third to the fifth decades. Their youngest case was two years of age and the oldest seventy-five. Only about one-fourth of their cases were less than thirty years old. Although many sarcomas are noted in the younger age groups, the older age groups are by no means excluded.

#### SEX

In general, most statistics show a higher preponderance of this condition in males. The ratio of

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males to females was 6 to 4 in Quick and Cutler's group, and 2.3 to 1 in Kaplan and Rubenfeld's series.

#### LOCATION

According to most reports, sarcoma of soft tissue occurs most frequently in the extremities, with the lower limb the site of predilection. Bick in his analysis of muscle sarcoma cited 16 of 20 cases in the thigh, abdominal wall and forearm. In a later report on fibrosarcoma of the extremities, this same author<sup>2</sup> listed 27 in the lower extremity and 15 in the upper extremity. Of the former, 23 (85 per cent) were found in the thigh; of the latter, eight (53 per cent) were located in the forearm. Of the 78 cases reported by Kaplan and Rubenfeld, 37 occurred in the lower extremity.

#### DURATION

In all of the series reviewed, the duration of the tumor mass was extremely variable—from three weeks to four years. The significant point emphasized by all reporters, is not the absolute time of existence of the tumor, but the period during which rapid or obvious growth takes place.

#### PATHOLOGY

Sarcomata infiltrate and penetrate the connective tissue framework of the area involved. Rarely does a definite line of demarcation occur. The malignancy of sarcoma varies as does that of carcinoma. Quick and Cutler have proposed a method of grading sarcomata based upon their relative cellular and fibrous content. They suggest three grades; grade one composed of relatively acellular fibrous tissue (low grade of malignancy), grade three of highly cellular tissue in a loose fibrillar net work (highly malignnat), and an intermediate grade between these two. Metastases occur in sarcomata but according to Ewing<sup>9</sup> usually take place directly through the blood channels rather than through lymphatics. Hence, enlargement of the regional lymph nodes does not occur with the same regularity in metasatic sarcoma as it does in metastatic carcinoma. Metastases most frequently occur in the lungs arriving through the blood stream. This early invasion of the blood stream is the chief obstacle to the successful treatment of sarcomas.

#### BIOPSY

Biopsy according to many should not be postponed for fear of activating a low grade process. Punch or aspiration biopsies are popular.

#### TREATMENT

The following statement by Stewart and Copeland summarizes the present status of treatment of this condition. "After detailed study of the material of the Memorial Hospital, we are still unable to determine how the disease should best be treated." External irradiation alone has produced some excellent results. Many survivals beyond the arbitrary five years have resulted from amputation. The general concensus, however, favors combined surgical and roentgen ray therapy.

The following case of a soft tissue sarcoma of the thigh diagnosed by biopsy and surviving ten years following roentgen ray therapy, is sufficiently rare to warrant a report.

#### CASE REPORT

L. B., a 30 year old white male was admitted to the New Britain General Hospital on October 4, 1937 with a chief complaint of pain and swelling of the right thigh. The patient bumped his right thigh while working in a local factory six weeks prior to admission, and the extremity subsequently began to swell and became painful. He continued to work,



FIGURE 1

Clinical photograph from the files of the New Haven Hospital, New Haven, Connecticut, November 23, 1937. (Photograph by courtesy of Dr. Samuel C. Harvey)



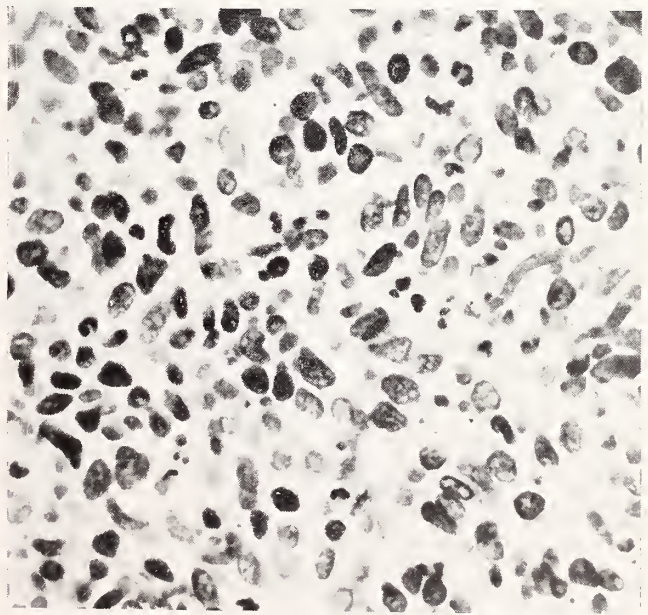
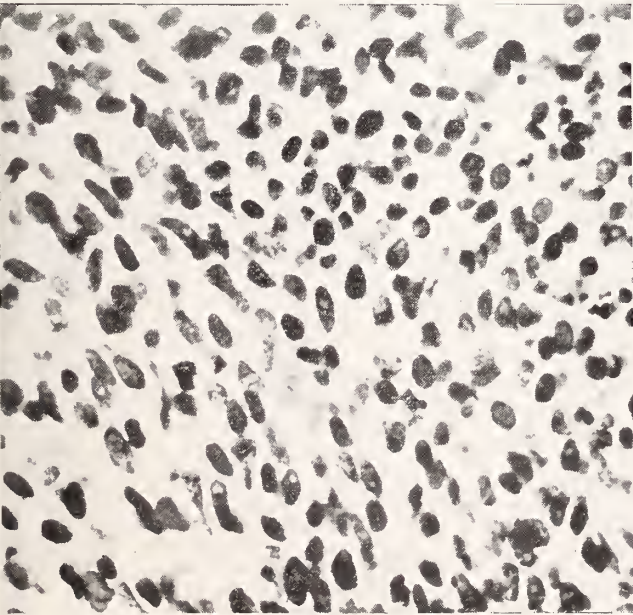


FIGURE 2

Roentgenograph of right thigh. September 30, 1937

however, until six days prior to admission to the hospital. A review of the patient's body systems revealed only that his weight had diminished approximately ten pounds in the three weeks preceding admission. The patient contracted the usual childhood diseases, but there had been no previous hospital admissions, operations or accidents. He is one of three siblings. One brother, one sister, and the mother were living and well. The cause of the father's death was unknown. Physical examination on admission revealed a well developed, well nourished, white male complaining of pain in the right knee. His temperature was  $100^{\circ}$  F., the pulse rate, 90, respirations, 24, and blood pressure, 128/78. The outstanding physical findings were elicited in the right lower extremity. The lower two-thirds of the right thigh was firm, uniformly indurated and tender. It was approximately twice the size of the left thigh (Figure 1). Clinical laboratory procedures revealed a negative Kline Exclusion Test and an essentially normal urinalysis. A blood count was not reported. Roentgenograph of the right femur (Figure 2) utilizing the soft tissue technique, showed a large, soft tissue mass occupying the lower two-thirds of the upper right leg extending from the knee to about 10.0 cm. below the greater trochanter of the right femur. The upper border of the mass was not sharply demarcated and the muscle lines were completely obliterated in the lower portion of the leg anterior to the femur, and partially obliterated posterior to the femur. A roentgenograph of the chest did not reveal metastases. An aspiration biopsy from the tumor of the right thigh was performed on October 5, 1937 and the pathologic report follows:

"The specimen consists of approximately 3 cc. of thick, bloody, semi-liquid material in which are many small shreds of tissue. Smears stained by the polychrome methylene blue method show masses of cells which are oval or spindle shaped. Their nuclei are usually elongated and deeply staining and large in comparison with the cytoplasm. Inflammation



FIGURES 3 AND 4

Photomicrograph of Hematoxylin-Eosin stained material obtained by aspiration biopsy. 600 x



tory cells are not noted. The impression is that the cells are representative of a sarcoma arising from soft tissue, the exact nature of which cannot be determined. The material is embedded in plasma and fixed in formalin for permanent staining. Hematoxylin and eosin stained preparations (Figures 3 and 4) show a few sheaths of cells and numerous scattered cells in lakes of blood. The cell nuclei are all hyperchromatic. Many are elongated. Others are oval and a few are round. A rare mitotic figure is seen, and occasionally a nucleus is irregular and deeply staining, giving the impression of being about to undergo mitosis. In a phosphotungstic acid stained preparation one zone suggesting neuroglia fibers is seen. Pathologic diagnosis: Soft tissue sarcoma, stem cell not definitely identified but probably fibroblastic with neurogenic origin a distinct possibility." A smear and culture of the aspirated material were obtained. Organisms were not seen on the smear. Gram positive cocci identified as staphylococcus aureus were cultured but were considered a contaminant. On the basis of these findings an amputation of the right extremity was advised. The patient refused amputation and was discharged from the New Britain General Hospital on the tenth hospital day to the Memorial Hospital in New York City for further investigation and treatment. An abstract of this patient's record at the Memorial Hospital was graciously furnished by Dr. Bradley L. Coley. It follows: "Mr. L. B. was admitted to the Memorial Hospital on October 19, 1937 with a large, slightly inflamed, non-tender swelling extending from the upper third of the femur to the knee. This area was diffuse and measured 38.0 cm. x 48.0 cm. in circumference at its widest diameter. After reviewing x-rays and slides, Dr. Norman L. Higinbotham, of our department, made a note that it was his impression that this was a periosteal fibrous sarcoma of the right femur. On October 26, the maximum circumference of the thigh was 53.0 cm. An aspiration biopsy done October 22, 1937 was reported by Dr. Stewart as follows: 'Spindle cell sarcoma—origin not determinable on smear.' The Wasserman and Kahn tests were negative. The x-ray department rendered the following report dated October 19, 1937: 'No evidence of metastases is seen in this film of the lungs. Views of the right hip reveal evidence of a huge, soft part tumor, apparently not arising from the shaft of the femur. The femur shows atrophic changes and some thinning of the cortex, with widening of the entire medullary portion. However, it is believed that these changes are incidental to the soft part tumor.' In view of these findings at the Memorial Hospital amputation was suggested but the patient again refused. He did, however, receive roentgen ray therapy at their institution. This consisted of irradiation to the right thigh through eight portals. Two areas were treated each day, 250 R. units per treatment. This therapy was given over a period of 26 days and constituted a total of 1,750 R. units to each of the eight portals. Following discharge from the Memorial Hospital the patient returned to his home, but because his symptoms continued unabated he sought help at the New Haven Hospital in New Haven, Connecticut. A review of their record reveals essentially the same findings as reported by the New Britain General Hospital and the Memorial Hospital. However, no biopsy of the lesion was taken at the New Haven Hospital, nor was roentgen ray therapy given. An amputation was also advised by the New Haven group, but as in all previous instances the patient refused and returned to his home in

New Britain, Connecticut. Approximately one month following his discharge from the Memorial Hospital in New York he came under the care and treatment of a "naturopathic physician." These treatments as far as we are able to determine consisted of baking with heat lamps and massage. While being treated by this "naturopathic physician" the tumor mass began to diminish in size and subsequently disappeared. Numerous attempts to follow the patient by the Department of Public Welfare of the City of New Britain were made but were generally unsuccessful because the patient was very uncooperative. He refused to attend the Tumor Clinic at the New Britain General Hospital for follow-up study, and gave full credit for his recovery to the "naturopathic physician."

In September of 1946, an interview was obtained with the patient. Reluctantly he revealed that he has been working a regular eight hour shift in a local factory for several years. While occupied at his work he maintains a standing posture. His employer states that he is a very dependable and productive worker. During the interview he was reluctant to give any information about himself and refused to be examined, but he was observed to walk without obvious impairment of gait.

#### COMMENT

A ten year survival of a patient diagnosed as having a soft tissue sarcoma treated by roentgen rays alone is unquestionably a rarity.

The diagnosis of sarcoma was made independently by the pathologists at the New Britain General Hospital and at the Memorial Hospital. To further confirm the diagnosis, stained and unstained preparations of the material obtained by aspiration biopsy were recently sent to several prominent pathologists together with a brief history which did not record the fact that the patient had survived ten years after roentgen ray therapy alone. One pathologist<sup>10</sup> stated that he felt the lesion was definitely a sarcoma but he was unable to identify its origin. Still another pathologist<sup>11</sup> replied "there is no question in my mind that this is a spindle cell sarcoma." A third pathologist<sup>12</sup> listed the possibilities of the lesion as either a malignant schwannoma, a leiomyosarcoma, or a metastasis from a sympatheticoblastoma, with a leiomyosarcoma being the most likely probability. This unanimous opinion of several pathologists that the original lesion was a malignant sarcoma indicates that the tumor fulfills the current morphologic criteria for a diagnosis of malignancy. Unfortunately the biologic proof of malignancy, utilizing the method described by Greene,<sup>13</sup> was not available at the time of the biopsy.

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## THE DIAGNOSTIC CLINIC

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MANY YEARS ago, while the field of medicine was still so small that it could be encompassed largely by the general practitioner, there was no serious need for a Diagnostic Clinic. With the rapid growth of the field of medicine in the past half century, however, it has become increasingly obvious that no one physician can hope to cover adequately more than a fraction of the field with its many allied sciences and professions. Formerly, when diagnostic and therapeutic problems became too difficult for the general practitioner to manage, an attempt was made to have such patients transferred to the hospital of a medical school. This service, obviously, was largely only available to the wealthy patient, the patient without means who already lived near the university hospital and who could be admitted to the ward service, or the patient whose expenses could be met by a charitable organization or by the collective financial aid of the patient's relatives or friends. As a result of the obvious need for diagnostic and therapeutic skill, not always available from practitioners of medicine, groups of physicians organized themselves into clinics. Some of these clinics were set up as Diagnostic Clinics only, while others were organized to provide both diagnosis and therapy. Thus, specialization has been a normal response to the demand for greater and more detailed knowledge of the individual branches of

medicine. Specialization and the expensive diagnostic and therapeutic equipment and material needed and used in modern medicine have very materially increased the cost of medical care in general, and have made the cost of catastrophic medical care prohibitive to most families. It is more and more obvious, with the passage of time, that the constantly rising cost of medical diagnosis and care must be levelled off and decreased if it is to be available to any large per cent of the American people. Aside from nursing care and the purely hotel side of the hospital, much of this high cost from the purely medical angle stems from three main sources:

(a) The fact that, in many instances, there is a large overhead of expensive equipment and personnel in the individual offices of numerous practitioners. The overhead must be met by charges of larger fees to the patients.

(b) The specialist charges fees which are often prohibitive to the average patient. His overhead expenses are similar to or often greater than those of the general practitioner.

(c) Much of the very expensive diagnostic and therapeutic equipment, and the space which it occupies, in the physician's office, the clinic, and the hospital, is actually in use for only a fraction—four to eight hours—of each day.

The increased costs of (a) can be and often are reduced by groups of physicians who are willing to utilize a large, common space where diagnostic and therapeutic equipment and personnel are shared, to as great a degree as is practicable, by the entire

group. This is a form of group practice even though there may be no central control for the reference and guidance of patients and for the proportionate sharing of expenses. In the formal group practice method there is a central business and professional control system which may determine the manner of reference, the guidance of the patient and a pre-arranged fee schedule, with equal or proportionate distribution of the group income. The increased cost of medical care as contributed to by (b), the specialist's fee, may be reduced or controlled by a group organization. It readily can be seen that if the specialist can use common space and, to a degree, common diagnostic x-ray and laboratory equipment, it should be possible for him to reduce his fee to a considerable degree. The increased cost of medical care as affected by (c) varies rather widely. The technical personnel of the hospital in both laboratory and x-ray departments have, traditionally, become accustomed to an 8 A. M. to 4 P. M. or 9 A. M. to 5 P. M. working day. The nursing service continues to cover the twenty-four period, in shifts, and the kitchen and maintenance services are often covered for extensive fractions of the twenty-four hour period. It does seem, with all of the extremely expensive equipment in mind, that it could and should be used for longer periods by having, for example, two shifts of technical personnel perhaps on an alternating 8 A. M. to 4 P. M. and 4 P. M. to 11 P. M. basis, so that equipment might be used more efficiently with less crowding of the present peak load period of 9 A. M. to 12 noon and 2 P. M. to 5 P. M. The peak periods just mentioned might then be used for the fluoroscopic, therapeutic, and highly technical laboratory procedures which require the skill and guidance or close supervision of the roentgenologist and the pathologist. The earlier and later periods might then be used for the routine procedures which can be done by skilled technicians without close professional supervision or with such supervision as can be provided by a hospital resident group. Such a system would allow more rapid and efficient work-up of patients and thereby reduce the period of diagnostic study from a usual range of seven to twenty-one days to a range of three to five days. In this manner many hospital beds, which are always at a premium, could be freed and utilized to care for a very much greater number of patients each year. Long waiting lists could thereby be happily shortened. With ever increasing demands for hospital beds, from the public and from the members of Blue Cross and other hospital insurance plans, it

behooves our hospitals to utilize more efficiently their beds and equipment. Such a system would also make it possible for every hospital building program to be more significantly helpful to the area served.

The community hospital is being looked upon increasingly as the expected center for the medical care of the community whether that community is a village or a city and whether the hospital is a small, non profit hospital or a large university or teaching hospital. This is a privilege and opportunity which must not be overlooked by the medical profession, but, like all privileges, it carries a great responsibility for better and more efficient medical care of the village, city, area, or state involved. There is no reason why the community hospital cannot and should not become the diagnostic center,—diagnostic clinic, if you will—for the area which it serves. Young men in their training period (interns, assistant residents and residents) could be expected to take the medical history and perform the initial physical examination under the supervision of more mature physicians. The Diagnostic Clinic thus becomes the center for the better training of young physicians as well as a reduced cost diagnostic boon for the average patient. Here, also, the younger men in medicine may become immediately productive, both medically and financially, rather than undergoing that long period of demoralizing inactivity that so frequently follows the period of hospital training while the young physician is establishing his practice. These young men should be paid \$5 or \$10, or more, per session or per unit of work involved.

In such a system there must be a group of highly trained specialists, members of the various American Boards of Specialists or their equivalents, who are willing to serve in the capacity of consultants for a reasonable fee. If specialists are willing to be assigned to the Diagnostic Clinic on a regularly specified time and appointment system, obvious inactivity and waste of time can be easily avoided.

It should not be forgotten that there must be a selective routing system whereby a mature, experienced physician, or group of physicians, will be responsible for starting the patient on his diagnostic study, helping the member of the Resident Staff to select, in a carefully individualized manner, the necessary diagnostic procedures and, finally, sitting down with the resident or younger staff man to arrive at the discharge diagnosis and therapeutic suggestions in preparation for the patient's return to the physician by whom he was referred for study.



All too frequently in the Diagnostic Clinic there is a demand on the part of the patient, or even by the referring physician, for many x-ray and laboratory examinations which are not really necessary. In order to keep the cost of the Diagnostic Clinic within a reasonable range, it should be understood that all essential routine examinations will be made, but that no expensive diagnostic procedures will be performed unless they are truly indicated. This decision should remain with the mature routing or control physician, and it should be recognized and accepted by the patient, the specialist, and the referring physician. This does not mean that the medical welfare of the patient should be jeopardized by too severe restriction of diagnostic procedures, but it should mean, for example, that x-rays of the skeletal system, gall bladder and gastro-intestinal tract, and genito-urinary system will not be taken without adequate indications. All too frequently the patient and even the referring physician are intent on "shooting the works" in a totally blind manner because of cancerphobia or one of the less frequently recognized psychiatric conditions. The Diagnostic Clinic, in order to avoid unnecessary expense for itself and the patient, can, therefore, avoid such a careless system by means of proper routing and co-ordination by the control physician or physicians.

The psychosomatic aspects of medicine must be seriously taken into consideration in the organization and operation of any diagnostic or combined diagnostic and therapeutic clinic. Failure to recognize this increasingly important phase of medicine will, most certainly, court inadequacy and failure.

Much of present day diagnostic work is carried out in hospitals where patients are admitted to the hospital, and therefore occupy a hospital bed for three to twenty-one days while their diagnosis is being established. Careful study will disclose that a surprisingly large number of these patients are really not "bed patients" but often needlessly occupy hospital beds because the Blue Cross plan and many other hospital insurance plans will meet all or a part of their expenses only if they are actually admitted to the hospital as an in-patient, i.e., a bed patient. Thus, this large group of patients occupies, needlessly, the expensive twenty-four coverage of the hotel and nursing services of the hospital and there are, as a result, many fewer beds available for patients whose diagnosis and therapy cannot be carried out other than in the hospital. This obviously expensive and inefficient plan should be changed. Such a

change is possible if the Blue Cross and other hospital insurance plans will expand their policies to cover at least a reasonable share of ambulatory diagnostic costs. It is recognized that there would still exist an abuse of in-patient versus out-patient insurance plans unless a reward system could be used. This might function as follows. All professional and service charges for the ambulatory patient might be met by the Blue Cross or other insurance plans, while, if it were necessary for the patient to be admitted as an in-patient, only charges such as the service and professional charges would be met, the remaining or purely hotel charges being paid by the in-patient. Such a plan, or a modification thereof, would offer very practical and financial encouragement for a more practicable, quantitative, and less expensive volume of ambulatory patient coverage and would, by the recognition of and charging for the purely hotel part of the expense, discourage the unnecessary use of hospital beds by patients who do not actually need such twenty-four hour care and coverage. It would be necessary, if such a plan could be worked out, for Blue Cross and other insurance plans to recognize and finance diagnostic coverage only in those clinics and centers of good medical standing, rather than in carelessly organized, self-styled clinics.

No discussion of the Diagnostic Clinic is complete without mention of the usual range of charge to the patient. The purely charity or very low income type of clinic makes charges ranging from zero to \$2 per visit, and must obviously be supported by additional financial aid from private charities, industry, Community Chest, or from local, state or federal government. The non profit clinic makes sufficient charges to cover all or part of the expense of the diagnostic workup. Such charges usually range from \$25 to \$100 for the ambulatory service, and \$75 to \$250 for the in-patient diagnostic service. Since the close of World War II many small, and a few larger private diagnostic clinics have been established. These clinics are, for the most part, strictly private clinics with charges based on a "cost-plus" system, or a system wherein each professional and service item is listed separately or is charged in an all inclusive lump sum.

The purely Diagnostic Clinic has as its goal the establishment of the diagnosis and carries out no therapy or, at least, not more therapy than is required to assist in establishing the diagnosis. There are only a few purely diagnostic clinics in this

country at the present time, of which the Pratt Diagnostic Clinic in Boston is one example. The Pratt Diagnostic Clinic, for example, accepts only such patients as are referred by a physician. This plan has several important aspects which strengthen patient-physician relationship and also make for better patient follow-up and care. By taking only patients referred by a physician, these patients can then be referred back to the local family physician with the diagnosis and a suggested plan of therapy. Too often when any clinic attempts to carry out the follow-up treatment of an out-of-town patient, a serious additional economic burden is placed upon the patient because of travel expense, hotel bills, etc. If the clinic accepts the follow-up care of the patient, the assumption is frequently made that only in the town or city where the clinic is located can therapy be carried out! In the majority of cases such an assumption is fallacious. The clinic is not usually able to carry out emergency care, if and when unforeseen complications arise out of clinic hours. There are many adequate reasons why the patient should have his local or family physician to whom he can turn in both the emergency situation and the routine carrying out of the designated therapeutic procedure and follow-up. True, the major specialty and surgical procedures such as brain and chest surgery, for example, should only be performed where there are adequately trained specialists, but the great majority of the recommended procedures can and should be carried out in the community hospital or the community from which the patient was referred for diagnosis. An example of the great and unnecessary wastefulness not infrequently seen in this respect is that of a well known Eastern clinic which frequently asks that patients return a distance of one hundred to three hundred and fifty miles for a basal metabolic rate determination or an electrocardiographic tracing. These procedures can now be done accurately in the majority of remote villages and towns in our nation, and at a great saving to the patient. A copy of the results can then, of course, be sent to the particular Diagnostic Clinic so that it may be available for the record and serve as a basis for further therapeutic suggestions.

Another important reason for insisting that a physician refer patients is the avoidance of unnecessary medical shopping by patients, from clinic to clinic, at a tremendous additional cost in money and an overlapping of medical effort. These "shopper" patients all too frequently have no family physician or medical guide as a result of their having con-

stantly moved from physician to physician and from one clinic to another, never remaining under one medical guide long enough to receive benefit from either diagnostic studies or follow-up therapy. This is most often true of that very large group of psychoneurotic patients.

Insistence upon referral by a physician, preferably the family physician, also provides an excellent opportunity for the physician to be brought up-to-date medically by the detailed report of diagnosis and the suggested plan of therapy. If each record is complete and thorough in unfolding the diagnosis and explaining the necessary therapeutic steps, it has tremendous value as a form of postgraduate medical education for the referring physician, whether he is located in a distant rural area, a nearby town, or in the same city.

It should be remembered that the ills of approximately 85 per cent of patients can be adequately treated by the family physician and that of the remaining 15, 10 to 14 can receive the necessary additional care in the local community hospital. This, obviously, leaves only 1 to 5 per cent of patients who may truly need the services available alone in the large hospital or medical center with its staff of highly trained specialists. It is quite idealistic, and perhaps unrealistic, to expect that only those people will come, or be referred, to the Diagnostic Clinic or large teaching hospital who really need the services which are available in such places alone. Unfortunately, human nature is such that "the grass on the other side of the fence appears greener" and expensive medical care can always be expected to attract a certain number of medical shoppers from a great distance! This is also frequently true of the family of the patient who has been given a hopeless prognosis, by a small or a large community hospital, and who take the patient from one medical center to another in a vain quest for a cure.

#### SUMMARY

1. It is recognized that the field of medicine and its allied sciences and professions have become so extensive that Diagnostic Clinics, or centers where experts can work together in cooperation for the better medical welfare of the patient, are a necessity.

2. Aside from the appreciable nursing and purely hotel expense encountered by the patient, the professional cost of medical care is often excessively high because of the added burden of unshared overhead expense on the part of the practitioner and the specialist. Even the hospital is not blameless in this



respect with much of its expensive diagnostic and therapeutic equipment utilized for only small fractions of the twenty-four hours of the day. This decreases the total number of patients who might benefit thereby and increases the cost of hospital care by extending the period of hospitalization.

3. The Community Hospital should become the Diagnostic Clinic, or diagnostic center, for the area served.

4. The Community Hospital, as a Diagnostic Clinic, can become the training ground both for new medical graduates and those young men who have finished their hospital training but are in a period of relative inactivity while they are building up their practice. These men should have conscientious and adequate supervision of their work by older, more mature physicians. These younger men should not be expected to contribute their services gratis, but should be adequately reimbursed for their services in the clinic.

5. The Diagnostic Clinic must be supervised by a mature, experienced physician or physicians who can be the control or routing physicians, so that inefficiency and unnecessary expense can be avoided for

both the patient and the clinic or hospital in the medical workup.

6. The psychosomatic aspect of the Diagnostic Clinic must be stressed if the clinic is to perform its best service to the medical community.

7. Hospital insurance plans should include coverage for the ambulatory patient in the Diagnostic Clinic. This can be made practicable by adjusting the present system so that hospital beds will be used only by those patients for whom they are needed, with consequent encouragement and stimulation of the less expensive ambulatory diagnosis.

8. The Diagnostic Clinic can extend its sphere of influence and helpfulness to the referring physician by referring the patient back to his family doctor, or his community, for all procedures which can be carried out adequately in the patient's home or community hospital. This plan can also aid, materially, in reducing the cost of medical care.

9. The Diagnostic Clinic, or center, can be responsible for progressively better and more adequate medical care for the patients of its area. At the same time it can be an ever stronger focus for improving graduate and postgraduate opportunities for the physicians of the area served by it.

## VOLUNTARY MEDICAL PREPAYMENT PLANS AS THEY APPLY TO RURAL COMMUNITIES

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A REVIEW of the history of voluntary medical prepayment plans reveals that in their modern concept they are strictly American. The oldest of American plans is the Northern Pacific Railroad Benefit Association which was organized in 1882 and has operated continuously since that date. Prepayment plans have developed through industrial establishments, universities, consumer and cooperative groups, various governmental units, Blue Cross and medical societies or groups of physicians. In addition, insurance companies have offered various

types of health and accident coverage to the public. The medical profession has contributed to the successful operation of all of these plans.

Efforts are being made to obtain accurate figures on the number of people covered by these various voluntary prepayment plans. At present any figures must be considered as estimates as no way has yet been devised to eliminate duplications in cases where people have subscribed to two or more of these plans.

I am indebted to Mr. L. S. Kleinschmidt, of the Division of Prepayment Plans of the Council on Medical Service, for the factual data given in this paper. The closest estimates obtainable today indi-

*Presented at the National Conference on Rural Health, Chicago, February 7-8, 1947*

cate that the total number of persons covered by the various types of voluntary prepayment plans is as follows:

TYPE OF PLAN	TOTAL COVERAGE	YEAR OF INFORMATION
Industrial .....	1,516,000	1945
University Student .....	100,000	1943
Consumer and Cooperative.....	504,000	1943-45
Governmental .....	580,000	1945-46
Blue Cross .....	25,000,000	1946
Medical Society and Physicians Groups .....	5,000.00	1946
Subtotal .....	32,700,000	
Insurance companies .....	13,340,000	1945
Hospital and surgical expense.....	30,660,00	1945
Accident and health coverage.....	44,000,00	
Total .....	76,700,000	

Progress was slow in the beginning. Expansion of plans as we know them today has occurred largely during the past ten years and the major increase in enrollment in the past three years.

The prepayment plans for medical care received their first impetus as a result of the phenomenal success of the Blue Cross Hospital Service Plans. With both the hospital and the patients in need of some sort of program to ease the burden of hospitalization costs, these plans grew rapidly. Today the term "Blue Cross" is recognized by almost everyone in the United States.

Using the experience of prepayment hospital plans as a guide, a number of state medical societies undertook to develop medical care plans. The first statewide plan was the California Physicians' Service organized in February 1939. Within a year Michigan Medical Service was organized. These two plans, together with the county medical society bureaus of the States of Washington and Oregon gave the medical profession the necessary experience upon which to build what has now become a nationwide movement.

The growth of medical care prepayment plans since 1939 has almost paralleled that of the hospital service plans. It took Blue Cross between five and six years to place thirty-eight plans in operation. This compares favorably with the six years it took to develop thirty-seven medical care plans. The same comparison can be made with reference to enrollment. In their first seven years medical care plans

enrolled 2,845,000 while Blue Cross enrolled 2,870,000.

The development of prepayment medical care was in many ways more difficult and complicated than that of hospitalization. Hospital care is a more unified service with relatively few procedures involved, whereas medical care included an almost unlimited variety of services. The problems involved in the payment and handling of claims for medical procedures are far more difficult than those for hospitalization. Years of experimenting with various methods has resulted in definite progress toward essentially sound advancement. Hospital care plans deal with a relatively few institutions where as medical care plans deal with several hundred or even thousands of doctors. A medical care plan then to be practical must not rely upon a relatively uniform institutional point of view but actually upon a host of individual attitudes if we are to retain a high quality of medical care.

The growth of voluntary health care insurance plans since 1939 has been most remarkable. Counting the 28 local plans in Washington and Oregon as two statewide plans, there are now 58 medical care plans sponsored by medical societies or Blue Cross. Plans are now in operation in 33 states and are in the process of formation in 13 more states and the District of Columbia. This leaves but two states, Mississippi and South Carolina, without some development reported to us. The fact that not one of the medical society prepayment plans has failed since 1939 and that the rate of growth has been rapid and steadily increasing attest to the application of common sense and to the desire of the medical profession to have prepayment medical care of a high quality available to all the people.

THE A.M.A. TEN POINT PROGRAM

The House of Delegates of the American Medical Association in their annual session at Chicago in 1945 adopted the following resolution: "The Board of Trustees and the Council on Medical Service will proceed as promptly as possible with the development of a specific national health program with emphasis on the nationwide organization of locally administered prepayment medical care plans sponsored by medical societies."

The Ten Point Program recommended: 1. Minimum standards of nutrition, housing, clothing, and recreation are fundamental to good health. 2. Preventative medical services should be available to all



and should be rendered through professionally competent health departments. 3. Adequate prenatal and maternity care should be made available to all mothers. 4. Every child should have proper attention including scientific nutrition, immunization, and other services included in infant welfare. 5. Health and Diagnostic Centers and hospitals necessary to community needs are preferably supplied by local agencies. 6. Voluntary health insurance for hospitalization and medical care is approved. 7. Medical care, including hospitalization to all veterans should be provided preferably by a physician of the veteran's choice. 8. Research for the advancement of medical science including a national science foundation is endorsed. 9. Services rendered by volunteer philanthropic health agencies should be encouraged. 10. Widespread education in the field of health and the widest possible dissemination of information regarding the prevention of disease and its treatment.

In order to implement the sixth point relating to voluntary health insurance, the Council on Medical Service established certain minimum standards of acceptance. These are: approval by the state or local medical society in the area in which it operates, the assumption of the local medical profession of the responsibility for a high grade of medical care, the free choice of physicians, the honest use of promotional material, the retention of the sanctity of the physician-patient relationship, accepted enrollment practices, and clarity of benefits. Plans meeting these requirements will be soundly organized. The plans which meet and continue to meet these requirements are given the "Seal of Acceptance" of the Council on Medical Service of the American Medical Association. Provisions are made for the frequent review of the plans and any found violating these fundamental principles of sound procedure may have their seal of acceptance revoked. On the other hand the Council being more concerned with healthy expansion of plans and benefits provides information and aid to all accepted plans and others seeking acceptance so that their service to the health needs of their communities may be continually broadened.

#### METHODS OF EXPANSION

With the experimental phases of medical care plans well under way more attention can now be devoted to expansion of enrollment and expansion of benefits with special attention to reaching rural subscribers. The Council on Medical Service has established a Division of Voluntary Prepayment

Medical Care Plans which acts as a clearing house of factual information, experiences, and successful practices of all operating plans, and by the constant interchange of this information, enables the rapid correction of unsatisfactory practices.

The expansion of enrollment and the expansion of benefits have been termed by Dr. H. H. Shoulders, president of the American Medical Association, as the vertical, which involves the question of how high up the scale of benefits indemnities or services can go under the insurance principle and how high the costs can go to cover these increased services; and the horizontal, involving the question of how far it is necessary to go to reach all potential subscribers.

The early plans in Washington and Oregon included practically all medical services, surgery, home, and office care, and even limited nursing and dental care. Throughout the years this broad coverage has been continued. The plans organized in 1939 and 1940 followed this lead and also provided for reasonably complete medical care. In contrast to the experience in the Northwestern states, the experience of the latterly formed plans with full coverage was unsatisfactory. It was found that the public would not pay the premiums necessary to carry out such a broad contract. Whenever a surgical contract plus a general medical care contract was offered to the public, the ratio of enrollment was more than 100 to 1 in favor of the surgical program. As a result the plans have generally preferred to begin operations with fairly restricted coverage such as surgical care, obstetrical, x-ray, and anesthesia in hospitalized cases. Now most of the services necessary in cases so severe as to require hospitalization are covered.

The tendency to limit services to those performed in the hospital is a natural one. In the first place most of the costly illnesses are those that require hospitalization. Secondly, there is going to be little abuse of such services. Thirdly, the actuarial experience in hospitalized cases is sufficient to provide plans with a more certain basis for determining adequate premiums. A recent study of fifty-one medical service plans shows that thirty-four of the plans offer surgical services, obstetrical and specified medical services in the hospital. This same study shows that plans are continuing to expand benefits. Twelve of the plans provide for general medical care, such as home and office calls, and five plans provide almost complete coverage.

The average premium for a single subscriber is

approximately \$1.25 and ranges from as little as sixty cents to \$4.85 a month. Family coverage ranges from \$1.35 to \$10 a month with an average of about \$3.

Plans are still experimenting with benefits and with premium rates. As one plan succeeds in some new idea, the basis for this success is made available to other plans. The same, of course, is true of failures. In this manner vertical expansion will continue to grow as actual experiences and public demand dictate.

Reviews of experience in rural areas have indicated that with the facilities available the rate of use under prepayment is higher than in the cities. The accumulation of physical defects and of chronic illness is greater. The risk of accidents is greater. Farmers are not usually covered by Workmen's Compensation. All injuries and illnesses automatically come within the scope of the prepayment plan.

The success of a plan offering general medical coverage depends on meeting the people's need for medical care with proper control of abuses and on the maintenance of the costs at a point consistent with adequate standards of service and at premiums salable to rural subscribers. It is the job of the medical profession to keep its members informed. So too, it is the job of the enrolling groups, whether they be factory, farm, or community to prevent the abuse of the benefits of the plans by their members. Equal interest in determining both coverage and premiums on a local basis should facilitate answers as to what additional medical services are needed, what the subscribers will pay, and what the plan charge must be to remain financially sound.

Horizontally, the expansion of the prepayment medical care program is limited only by the ability and willingness of the public to enroll as subscribers. It is true that most of the plans have tended to concentrate on urban areas where large group enrollment was possible. This was a sound method because the sooner a plan obtains an adequate risk spread, the sooner it can expand its benefits and enrollment program. Large group enrollment provides this spread more easily and with less acquisition cost.

However, the pattern is now changing and having reached a reasonable enrollment and a sound financial level, ways and means of reaching all population groups—particularly the rural—are being explored.

In general, the pattern has not been to deal with the farm group as a separate problem but to include

them in what is called community enrollment. In community enrollment the farmer is considered a part in the area encircling a town or village. Usually the town is the center for trading. The whole community then becomes a group with premium payments payable at some central place.

#### A METHOD FOR PROCEEDING

A successful Blue Cross enrollment campaign in rural areas was carried out in Colorado by the Weld County Agricultural Health Association. Enrollment was on a community basis reaching all elements of the community as a civic service. Weld County, the largest county in Colorado, is about three times the size of Rhode Island and has a population of 63,700. Greeley is the largest town in the county with 15,900 population, and there are several smaller towns. Prominent businessmen, farm organization leaders and various club leaders met with the Blue Cross representatives and decided to form a Health Association under the Colorado law governing co-operatives. Twelve directors, each representing a definite district in Weld County, govern the Health Association. This division provided workable units in size and population for an enrollment and administrative program. Enrollment was not limited to Blue Cross but each district was allowed to enroll separately in the Colorado Medical Service plan whenever fifty per cent or more of the families in the district had subscribed to the Health Association. To date Weld County has 8,000 participants enrolled. Colorado has organized ten other similar county health associations and thus have enrolled one in every six persons in rural areas and one out of every two urban residents.

Iowa has organized fifty-five similar County Health Improvement Associations. Other states are enrolling on a similar community basis with less formal organization.

Voluntary prepayment plans are growing rapidly in rural areas. A survey of Blue Cross Rural enrollment reported in November 1946 by the Blue Cross Commission shows an increase of 200 per cent since 1944. The study shows a total of 1,637,533 subscribers and dependents now as compared with 500,000 rural members in 1944.

Many medical care plans have developed their organizations to the point where rural enrollment is being carried on or plans are being made by those reaching into rural areas. A study of these plans now under way indicates that about one half of those doing rural enrollment, twelve plans, have



reported 304,542 subscribers and dependents. It is estimated that the study, when completed, will show medical care plans in a position comparable with Blue Cross of two years ago—or a half million rural members.

The problem cannot be solved at a national level. It must, to be successful, be worked out in the community where the need exists. There must be developed a community responsibility which will lend its active support if any effort is to succeed.

Continuing improvements in transportation and extension of better roads will accelerate the growing tendency of rural people to bring the patient to the physician. Thus the physician's care and the use of other health facilities can be extended over an area that includes a sufficient number of people to meet the costs of the services provided.

#### USE OF THE INSURANCE PRINCIPLE

A study of the fees for medical services rendered by the rural practitioners shows they are not excessive. However, there are times when illnesses strike and the severity of the cases cannot be predetermined. For this reason many farm families faced with severe illness find it difficult to meet the full costs from their income. This problem of meeting the costs is basically the same as it is with people living in towns. The only sound method so far devised is through the use of the insurance principle we have described. Prepayment medical care plans available to all people of a community, towns people and farmers alike, tend to spread the risk and distribute the costs. Thus, having the cost known in advance, proper planning and budgeting for these otherwise unpredictable costs is possible.

Families or individuals unable to pay the full costs of medical care from their incomes and those now receiving public assistance should be called upon to pay for their own medical care as far as is consistent with their incomes and provision made through locally administered public funds to pay the balance of the premium required to participate in a prepayment plan. Every effort should be made to help and not to pauperize or regiment the most individualistic element of our social economy—the American farmer.

The problem of the lower income groups can be solved by local communities and state actions in line with the rapidly developing voluntary prepayment medical care movement.

#### DIVISION OF RESPONSIBILITY

Who carries the responsibility for the medical care program? The physicians because of their special training cannot escape the responsibility for the professional aspects of the program. Experience has shown that they do not want to. The recipients of the medical service (the people) cannot escape the responsibility of paying the costs of the services. Both should do their full share in providing the needed facilities. With full cooperation of the medical profession and the people, working in mutual confidence, a medical care program can succeed by undertaking the various types of medical service one step at a time. As experience is gained, additional types of medical care can be included. Coverage may be as complete as is desirable in any community. Progress can be as rapid as experience indicates and the economic situation permits.

For ten years or more doctors have operated experimental plans in medical care insurance. On the basis of this experience they now feel ready to recommend prepayment plans to the people. The Council on Medical Service created by the House of Delegates of the American Medical Association has as one of its primary functions the fostering and developing of prepayment plans. The American Medical Associations have rural health committees devoting their attention to the rural problem as do the various State Medical Associations.

#### IT CAN BE DONE

Local representatives of farm organizations such as those present here today, together with business groups and local medical societies working in full cooperation and mutual confidence and understanding are now in a position as never before to work out this heretofore difficult phase of delivering medical care to all the people. And unfettered by the totalitarian ideologies of the old world we will continue to be "America, the land of individual opportunity."

## ANNUAL COUNTY ASSOCIATION MEETINGS

## Hartford, Tuesday, April 1

HUNT MEMORIAL BUILDING AND HARTFORD CLUB, HARTFORD

Business meeting 4:00 P. M.      Social half-hour 6:30 P. M.      Dinner 7:00 P. M.

*After-dinner Speaker:* William Wallace Scott, M.D., Professor of Urology, Johns Hopkins University School of Medicine, Baltimore*Subject:* "TREATMENT OF CANCER WITH HORMONES"

## New London, Thursday, April 3

SEASIDE SANATORIUM, WATERFORD

Business meeting 5:00 P. M.      Dinner 6:30 P. M.      Scientific meeting 8:30 P. M.

Speaker and subject to be announced later

*Speaker:* Charles Stuart Welch, M.D., Professor of Surgery, Tufts College Medical School, Boston

## Fairfield, Tuesday, April 8

STRATFIELD HOTEL, BRIDGEPORT

Business meeting 4:30 P. M.      Social Hour 6:00 P. M.      Dinner 6:30 P. M.

*Speaker:* Morris Fishbein, M.D., Editor of the *Journal of the American Medical Association*

## Middlesex, Wednesday, April 9

CLUB VASQUES, MIDDLETOWN

Business meeting 5:00 P. M.

Dinner 6:00 P. M. The Middlesex County Medical Association and The Central Medical Society will join in celebrating the centennial of the latter society

*Speakers:* Morris Fishbein, M.D., Editor of the *Journal of the American Medical Association*

James Murphy, M.D., Middletown, will give a paper on the

"HISTORY OF THE CENTRAL MEDICAL SOCIETY"



Tolland, Tuesday, April 15

OLDE HOMESTEAD INN, SOMERS

Dinner 6:30 P. M.

*Speakers:* Otto G. Wiedman, M.D. and Charles W. Stephenson, M.D., Hartford

*Subject:* "DIAGNOSIS AND TREATMENT OF EPILEPSY" (Illustrated)

Windham, Thursday, April 17

NATHAN HALE HOTEL, WILLIMANTIC

Dinner 12:30 P. M.

*Speaker:* John F. Fulton, M.D., Sterling Professor of Physiology, Yale University School of Medicine

*Subject:* "LEUKOTOMY"

Litchfield, Tuesday, April 22

Program and place to be announced later

LITCHFIELD COUNTY HOSPITAL, WINSTED

Luncheon 1:00 P. M.

Business meeting

Scientific program

*Speaker:* R. Starr Lampson, M.D., Hartford

*Subject:* "PROBLEMS IN THORACIC SURGERY AS SEEN IN A GENERAL HOSPITAL"

New Haven, Thursday, April 24

NEW HAVEN COUNTRY CLUB, NEW HAVEN

Business meeting 5:00 P. M.

Social hour 6:00 P.M.

Dinner 7:00 P. M.

Speaker and subject to be announced later

# CONNECTICUT STATE MEDICAL JOURNAL

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## EDITORIALS

### 1763 - 1947

The brotherhood of physicians, in other words the medical society, is as old in world civilization as recorded history itself. The ideals and motivations of the society of physicians of which Hippocrates himself was a member have given spirit to groups of doctors down through the centuries. From their very beginnings our own medical societies have pronounced these same loyalties as the reason for their existence. The idea of self improvement in order to improve professional service was not new in 1763 when eleven New London County physicians memorialized our colonial General Assembly. Quaint as their words are today they have living meaning as we read, "The Memorial of us the Subscribers Physicians in said Colony Humbly sheweth that whereas Life is the most Desirable of all Sublunary Enjoyments and Health so invaluable a Blessing that without it in some Degree Life is Little Worth And that the Promoting Medical Knowledge among Physicians is the Necessary and direct means to Restore health and even Preserve life and is of great importance as it will Render the Practice of Physic more safe and serviceable to the Patient And at the same time yeald more Satisfaction and Honour to the Profession."

It was this document written by Connecticut doctors which was the initial effort which later brought into being the Connecticut State Medical Society now about to hold its one hundred and fifty-fifth annual meeting. As a group of physicians

we are still devoted to "Promoting Medical Knowledge" as the announced program shows. As a society we have grown large, great in numbers and great in our responsibilities to the public which we serve.

Today medicine everywhere has extended its frontiers beyond that of other fields of scientific endeavor. New opportunities, new social relationships and new responsibilities confront us. As intelligent men the real task ahead is to recognize changes in values, to consider new possibilities and to realize that thought must be progressive and not static.

### The Hospital Survey and Construction Act

As physicians we must become familiar with the Hospital Survey and Construction Act, for under it this country will be engaged in the most comprehensive hospital program ever undertaken by any nation. Dr. Hilleboe's paper is an excellent statement of the aims and purposes of the Act which is to assist the States in planning and providing hospitals and health centers. An important principle embodied in the Act is that of decentralization, the Federal role being essentially one of guidance. The responsibility of carrying out the program will be at the community and state levels. This means that communities must furnish leadership and that physicians must share that responsibility.

Dr. Murdock's paper on Modern Influences in Medical Practice emphasizes the necessity for surveying hospital organizations. His plan for representation of physicians in hospital boards of directors



is a sound recommendation. Those who oppose this view on the ground of the possible malign influences of favoritism cannot have a very high opinion of the integrity of those members of the medical staffs of hospitals in whose hands the care of patients so greatly rests.

### The Cancer Fund

During the month of April the American Cancer Society seeks a national goal of \$12,000,000 to continue its great research program and to expand cancer education and service in the states. Of this amount the Connecticut Cancer Society has undertaken to raise \$277,440, the same quota which last year the people of Connecticut over-subscribed by \$15,000. Early in March volunteer campaign chairmen had agreed to serve in all but a handful of the state's 169 towns, and by now every community is covered. In many places the work is being sponsored by service clubs or other organizations.

This widespread interest has not been forced by high pressure tactics. The state campaign staff is a little band of workers who believe in what they are doing. The truth seems to be that the cancer society has merely given voice to a surging desire in the American people that a disease which so many families have experienced with pain and tragedy shall be brought out into the open and fought.

In the brief space of two years since 1945 when the Society first went to the public for adequate funds, the National Research Council has independently directed the coordination of cancer research projects into a mushrooming nationwide program supported by society grants. More than a dozen different investigations supported by these funds are under way in Connecticut alone.

Every community in the State has had its opportunity to develop local cancer control programs through committees of the Connecticut Cancer Society working with other local health groups under the guidance of interested physicians. Sixty per cent of the amount raised in the state is available for use here.

Many communities have been quick to grasp the opportunity. Tumor clinics have obtained needed personnel, grants have been secured to increase Visiting Nurse service, ten communities have opened information centers, cancer consultation or detection centers are functioning in Hartford, New Haven and Meriden, and one is being made ready in Bridgeport; local field army funds are used to aid

needy patients, cancer health films and talks by physicians are being scheduled at meetings in town and country. This is but a brief glimpse of work being carried on with funds from the Connecticut Cancer Society in cooperation with the State Medical Society and the State Department of Health.

But more than this, the cancer society seems to have captured the imagination of the people of Connecticut. Volunteer canvassers report that almost all who are reached are willing and even eager to give to this cause. They are satisfied that in this field as in the war America can once again "do the impossible." Furthermore, promising leads in cancer research have kindled confidence among scientists. A grim realization of the deadliness of cancer still exists among the people, but the defeatism of a few years ago has lifted.

By giving encouragement to the present cancer campaign and constructive leadership in community cancer control during the year, Connecticut physicians will be making the most of the new opportunities provided by these funds.

### The Diagnostic Clinic

This timely subject is discussed in this issue in an authoritative way by Dr. John C. Leonard, whose extended experience in this field is well known to Connecticut physicians. His recommendation that the community hospital become more and more a diagnostic center for the area which it serves has been emphasized by other authorities who also see a great economy in time and effort in such development. The war effort brought into sharp demonstration the fact that groups of physicians working in organized clinics or great hospitals can render a service unequalled by the individual practitioner. Furthermore, the development of the diagnostic clinic offers to the ambulant many of the diagnostic facilities which were formerly available only to those who were hospitalized.

Dr. Leonard's paper is a demonstration of thoughtful and constructive thinking. It bids fair to become a landmark for future developments in our State along the lines so well set down by the author.

### Breast Feeding as a Clinical and Social Problem

To a medical officer in charge of a health center in South Africa we are indebted for a very sane and enlightening discussion of breast feeding. This

author, basing his observations on experimental work of others, doubts the general efficacy of a strict four hourly nursing regime often imposed on lactating mothers. Also he believes the feeding of only one breast at a time, which means each breast is emptied only once in eight hours, would have similar deleterious effects on milk production since milk secretion is a continuous process. An analogy is drawn to the frightened, nervous cow which cannot "let down her milk." "The tense primipara, afraid of childbirth, with a tense cervix, a vivid imagination, with advice from elderly relatives, who is given a general anesthetic to keep her quiet during labour and who is then subjected to the rigid discipline of a modern maternity hospital, with its almost mechanical air of efficiency, should be forgiven for not 'letting down' her milk."

The role of visitors in diminishing milk supply comes in for its share of comment. Walsh and Stromme in 1944 found that 33.4 per cent of mothers had no wish to feed their infants. A suggestion which the authors considers well worth trying is to have the mother manually express a little milk before each feeding in order to clear the lactiferous ducts of any occlusive substance which may have collected. Physicians have been found, at least in one city, to be responsible more than any other agency for weaning babies unnecessarily. Feeding difficulties in the first few weeks of life must be taken much more seriously by the medical profession and not left entirely in the hands of the maternity nurse and health visitor.

Protein in the mother's diet has been found to increase the yield of milk. Massage of the breasts during pregnancy from the time colostrum starts to be formed will prevent enlargement by expressing secretion and clearing all obstruction to the flow of milk. The use of alcohol on the nipples is to be condemned. During the last weeks yellow oxide of mercury ointment should be used. One author doubts if the "grotesque advice" to scrub the nipples with a nail brush finds any woman with enough fortitude to obey.

Test weighing is something worse than tomfoolery. Often the twenty minutes has been utilized in some other way than in actual nursing and no one has remained with the mother to check up.

"The harm done nowadays is not confined to turning out badly trained nurses, but extends to the mothers who easily are led to believe that feeding is less an affair of technique than a sum in arithmetic,

and that if their babies don't thrive at the breast when 'clocked in' and 'clocked out' like factory hands, the sooner they are fed artificially and by measure, the better. Neither realizes that it is this absurd guidance by the clock which already constitutes artificial feeding; artificial because applied without understanding, it takes no account of the physiology of lactation or of the emotional side of motherhood and overlooks the baby's dependence on both if it is to thrive. I say that we must take the blame of having allowed this fragment of a scientific method to masquerade as the real thing. We must recognize that, whereas arithmetic is an invaluable aid to skilled nursing, applied in this way, it can introduce as many errors as it was designed to avoid. It leads, moreover, to a kind of slick, sham efficiency resting upon record books, charts and graphs, and all the false deductions so often drawn from them."

This situation must be attributed without doubt to the mechanical age in which we live and which has deprived us of us many of the simple and natural experiences of life. The maternal instinct today as in the days of our grandmothers finds a satisfaction in breast feeding the new arrival rarely matched by any other physiological process. The difficulty is that fashion and the example of the leading movie star discourage the expression of such homely, maternal instincts. The modern mother seems to lack the patience to teach the refractory infant that her breasts were intended for his use and, in her dilemma, finds little sympathetic aid from the staff of the maternity hospital. Perhaps if the maternal sense of responsibility weighed a little more on the shoulders of the new mother there would be less opportunity for criticism of the parents and the home for the juvenile delinquencies of later years. The problem is one deserving of more mature and thoughtful consideration.

### Prepayment Plans for Rural Communities

Dr. James R. McVay of the Council on Medical Service, A.M.A., discusses in this issue rural problems of medical care as they relate to insurance. Dr. McVay's paper is a fine exposition of the subject of medical insurance plan in general for he gives an excellent historical survey of the movement in America. It is important for our readers to become familiar with this background, for only by such understanding can we expect our own plans for medical insurance to function in a way which will be of greatest benefit to all concerned. His advice



concerning rural health plans will find warm response in those who see in the American farmer an individualistic element which is still the strong backbone of our social economy.

### The Private Office as a Health Center

If the general practitioner is unwilling or unable to do a health maintenance examination, the patient will perforce go to a clinic which has announced such a service. There has been much publicity lately on the importance of general physical examinations in the detection of cancer and in the maintenance of health. When a New York tabloid featured the opening of the Strang Clinic in New York, a flood of letters and calls poured in, and already that clinic is now booked until November 1947. Many of these applicants were willing and able to pay their private doctors for this kind of service. How many of their doctors were willing and able to render this service? The cry that the operation of such a clinic (whether designated a cancer prevention or a health maintenance agency) is a blow to individualized medicine, is constantly heard. It is fair to ask the complaining doctors if they are prepared to give their patients an equivalent service.

We frown on hospitals, agencies and clinics which do general physical examinations at cut rates because we see such activities as steps away from free choice, as examples of the corporate practice of medicine and as devices to cheapen the value of examinations. Our frowns will retain no patients however; our willingness to provide thorough diagnostic facilities in the office will.

At the moment, the best approach to health maintenance examinations is by way of "cancer prevention." This is a dramatic, attention arresting, and important basis on which to offer such a service. It goes without saying that the practitioner will really do a thorough study including vaginal and rectal examinations and a flat chest plate. As a practical suggestion, the doctor might send to A.M.A. headquarters for the excellent and useful *Physical Examination Blank* printed there. For the small sum of a dollar and fifty cents, the practitioner can have two hundred of these forms. If every suggested question is asked and every blank on the form filled in, the doctor will get an exhaustive overall understanding of his patient's status. The suggested examination procedures are within the skills and equipment of the general practitioner.

Patients have learned that a good physical examination including the history (and the drawing of specimens for blood count, urine analysis, blood serology) will take at least forty-five minutes. They will not be satisfied with anything more cursory. The doctor who is not prepared to devote the time and attention which this requires should send the patient to a colleague who is. If he fails to do either, let him not be surprised if the patient goes to a publicized health maintenance or cancer prevention clinic and gets a work-up at a reduced fee.

Follow-up is important, and doctors need no longer be deterred by fear that the patient will think he is trying to make an unnecessary fee. If, for example, a small mass is found, and biopsy does not seem indicated, a follow-up visit a few weeks later to see if the mass has grown, is sensible and the patient knows it is.

The demand for group medicine, for more clinics, for new health centers and the like is growing rapidly. A stand at this point, by offering complete diagnostic service, is the family doctor's chance to retain medical practice in its individualistic framework. It is, perhaps, his last chance.

*Reprinted from the Journal of The Medical Society of New Jersey*

### Appendicitis Mortality Approaching Zero

Few physicians are living today and fewer practicing who recall Reginald Heber Fitz's classical paper on "Perforating Inflammation of the Vermiform Appendix" published in 1886, in which, for the first time, was given a clear picture of the clinical course, diagnostic signs, and pathological changes of appendicitis. The epoch making procedure, radical operation, which Dr. Fitz advocated has borne fruit during these sixty years.

The Metropolitan Life Insurance Company reports that the mortality from appendicitis among its Industrial policyholders has been cut by more than one half in the past five years and by almost three-fourths in the past decade. The age-adjusted rate in 1946 was 3.2 per 100,000 (ages 1 to 74) as compared with a rate of 7.1 in 1941 and 11.5 in 1936. Metropolitan believes that within the next few years appendicitis will be reduced to a very minor cause of death in our country, and that medical science and public health administration will close another important chapter in their history.

Fifteen years ago appendicitis claimed about 18,000 deaths a year in the United States and the death rate was mounting in spite of greater hospital facilities and better medical and surgical skill. The results of immediate operation and a realization of the harm produced by laxatives taken after the onset of an attack resulted in a vigorous, nationwide educational campaign, in which people were urged not to delay calling a physician and were warned against the use of laxatives in the presence of abdominal pain. In this the Metropolitan took an active part, as well as pharmacists and pharmaceutical manufacturers.

A cursory glance at the death rates for the past five years shows that the mortality for this disease is rapidly approaching zero. Even in the age group from 65 to 74 years where there has been the highest mortality, we find a drop of over 50 per cent. The incidence of appendicitis seems to be increasing, but with the improvement in medical care and surgical treatment and the addition of chemotherapy the mortality continues to fall.

### An Alternate Plan

*The following letter from President Seymour of Yale University to Governor McConaughy is particularly important at this time. The previous discussions regarding medical education in Connecticut have been followed with great interest by physicians, legislators, and the public. The plan suggested by President Seymour brings realistic thinking to these considerations which will be greatly helpful in the planning of future developments in medical education in our State.*

#### OFFICE OF THE PRESIDENT

February 11, 1947

Honorable James L. McConaughy  
Governor of Connecticut  
Hartford, Connecticut

Dear Governor McConaughy:

You will recall our conversations with Dr. Darling in regard to medical education in the State of Connecticut. I understand that you have had before you the suggestion of a second medical school as part of the University of Connecticut involving necessarily a considerable financial commitment. May I suggest the following plan as a basis for discussion of a possible alternative.

You will understand, I am sure, the tentative character of the estimates given and the provisional

nature of any program which might be considered at this time. Obviously the development at Yale of such a cooperative procedure would call not only for agreement on important matters of University policy but the participation of the medical faculty and University officers in an analysis of instructional needs and clinical facilities before any definite commitment could be made. In spite of this, we feel that some figures might be useful to you for comparative purposes.

Without including special grants for research which fluctuate greatly from year to year and amount to more than \$600,000 at the present time, the University appropriations for the medical school for the current year total \$1,453,183. From this figure could be subtracted the University overhead allocation to the Medical School of \$202,834 and an allotment of \$150,000 up to the present made to the Grace-New Haven Hospital on a deficit guarantee basis, which really should be charged against medical relief and not medical education. This leaves a total of \$1,100,345 as the over-all cost for education.

On the assumption that ways might be found in the event of a State appropriation to increase the annual class from fifty to seventy-five students a year with twenty-five allocated to Connecticut men and women, the total enrollment would be three hundred. Expenses would increase perhaps by \$130,000. This would mean a cost per student of approximately \$4,100 a year. Tuition charges for the Yale Medical School have recently been raised to \$750 per year. The tuition for Connecticut students included in this plan might be made \$200. This would leave a balance of \$3,900 per student to be met by the State. If twenty-five students a year were included in this program it would mean a State appropriation of \$97,500 for the first year; \$195,000 for the second; \$292,500 for the third; and \$390,000 thereafter.

While this total provides what may be a too modest amount for increased expenses, it is felt that the University could undertake to absorb some additional costs, since this new money would in part improve the Medical School's total financial position which now operates at an annual deficit of \$713,000 a year.

If at any time you would like to discuss this plan or any modification of it we are at your service.

Faithfully yours,  
Charles Seymour



## THE PRESIDENT'S PAGE

**T**HE blinding floodlight of critical examination which fell upon medicine during the past few years has not been turned off. If anything, it has become more widely diffused. Some physicians have become conditioned to its smarting rays, and other lights in the sky have at times detracted attention from its searching beams.

Every physician should realize that governmental control of medicine remains a very present and horrid danger. Certain bills introduced in the 80th Congress indicate that medical care continues to be a live subject. Some of these bills in large measure are favorable to medicine *but they portend change*. The President has reiterated his demand for compulsory health insurance. It is widely rumored that soon the Wagner-Murray-Dingell Bill, clothed in new title and fresh habiliments, will strut upon the stage again.

As never before, the people are medicine and hospital conscious. High school students and scholars in social science; labor unions and manufacturers' associations; wealthy foundations and idle gossips, and just common folks, too, recognize the vital importance of health and the need for adequate distribution of medical care; and most have their own pet scheme for implementation.

Too many physicians are either oblivious of this or are too complacent about their own affairs to be concerned with the implications of any vast impending social change. Some are lulled by their present security, and some are certain that the shouting and tumult they vaguely hear is but the noisy aftermath of the war, and that soon all will be quiet.

The good old days, if indeed they really were good, are gone forever. Change is a law of life, and the changes to come in the science and practice of medicine should arise from the knowledge of physicians and should be planned and activated by physicians. Progressive improvement in methods for treating the sick, extension of adequate medical care to all of the people, and the advancement of health education offer opportunities for change that should challenge every physician. It should be the aim and desire of the medical profession that changes in these vital fields should grow out of the interest, intelligence, and application of physicians themselves.

Cole B. Gibson, M.D.

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## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

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### CALL

#### ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1947 Annual Meeting of the House of Delegates will be held on Monday, April 28, at the New Haven Medical Association Building, 364 Whitney Avenue, New Haven, beginning at 10:00 o'clock in the morning.

Members of the House will be the guests of the Society at luncheon.

Cole B. Gibson, *President*

Creighton Barker, *Secretary*

#### March Council Meeting

The regular monthly meeting of the Council was called to order by the Chairman, Dr. Murdock, at 3:00 P. M., Friday, March 7, 1947, at the offices of the Society. There were present: Drs. Murdock, Moore, Phillips, LaMoure, Thoms, Gildersleeve, Mullins, Weld, Howard, Barker, Miss Mooney. Excused: Drs. Gibson, Campbell, Miller, Speight, Weed.

Nominations of officers and committee members for the Society for the year 1947-48 were completed. In accordance with the by-laws, these names will be presented to the House of Delegates at the Annual Meeting on April 28.

It was agreed after discussion that the present Committee on Medical Care of Veterans should continue to serve for all purposes relating to this subject and that if necessary the Committee would serve as a Board of Review and Arbitration between physicians and the Veterans Administration.

The Council voted official approval and support of SB329, a bill now before the General Assembly providing for exemption of non profit hospitals from local taxation. A memorandum expressing the Society's support of the measure is to be prepared by a special committee consisting of Drs. Murdock, Howard and Barker and this memorandum will be filed with members of the Committee on Finance.

The sum of \$300 for secretarial assistance, supplies and other necessary expenses was allocated by the

Council to the Committee to Study the Organization and Objectives of the Society.

The program for the Semi-Annual Conference of Presidents and Secretaries of County Medical Associations was presented by the Secretary and a recommendation that the members of the Committee to Study the Organization and Objectives of the Society be invited to attend this Conference was approved.

It was voted that there be presented to the House of Delegates at its Annual Meeting a resolution asking that the Council of this Society be authorized to appoint a permanent committee of five members to study the care of the chronically ill.

After the meeting, the members of the Council adjourned to the Graduate's Club for dinner where they were joined by the Committee to Study the Organization and Objectives of the Society. After dinner, under the chairmanship of Dr. Murdock and Dr. Bishop, chairman of the committee, discussions were entered into concerning many phases of the Society's activities.

Friday, April 11, was set as the date for the next regular meeting of the Council.

#### Meetings Held During March

Wednesday, March 5, 7:30 P. M.

Joint Conference Committee with the Connecticut Pharmaceutical Association



- Thursday, March 6, 4:00 P. M.  
Program Committee
- Friday, March 7, 3:00 P. M.  
Council of the Society
- Tuesday, March 11, 10:00 A. M.  
Written examinations, Connecticut Medical  
Examining Board, Hartford
- Wednesday, March 12, 9:30 A. M.  
Written examinations, Connecticut Medical  
Examining Board, Hartford
- Thursday, March 13, 3:00 P. M.  
Committee on Public Health
- Friday, March 14, 6:00 P. M.  
Committee on Medical Care of Veterans,  
Graduates Club, New Haven
- Thursday, March 20, 4:00 P. M.  
Conference of Presidents and Secretaries of  
the County Medical Associations, New  
Haven Medical Association Building
- Tuesday, March 25, 4:00 P. M.  
Board of Trustees of the Building Fund
- Wednesday, March 25, 4:00 P. M.  
Committee on Maternal Morbidity and Mor-  
tality
- 7:00 P. M.  
Committee on Industrial Health

### Meetings Scheduled for April

- Friday, April 11, 4:00 P. M.  
Council of the Society
- Monday, April 28, 10:00 A. M.  
Annual Meeting of the House of Delegates,  
New Haven Medical Association Building
- Tuesday, April 29, 9:30 A. M.  
Annual Meeting of the Society, Hamden  
High School
- 7:00 P. M.  
Annual Dinner of the Society, New Haven  
Lawn Club
- Wednesday, April 30, 9:30 A. M.  
Annual Meeting of the Society, Hamden  
High School



### Editor of A.M.A. Journal to Address Two Connecticut Medical Groups

Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*, will be guest speaker at the annual meetings of two Connecticut medical groups early in April.

On Tuesday, April 8, Dr. Fishbein will address members of the Fairfield County Medical Association at their annual meeting at the Hotel Stratfield, in Bridgeport. The following evening he will be guest speaker at the 100th anniversary meeting of the Central Medical Society, Middletown.

Plans for the centennial observance will include presentation of the organization's history by Dr. James Murphy, retired staff member of the Middlesex Hospital, who in 1907 presented the history at the 60th anniversary meeting. Dr. Harry S. Frank is chairman of the committee planning the meeting, which will be held at the Club Vasques, in Middletown.

## Nominations for Officers and Committees 1947 - 1948

President-Elect Samuel C. Harvey, New Haven  
 First Vice-President Alfred Labensky, New London  
 Second Vice-President Francis H. Burke, Rockville  
 Treasurer Cole B. Gibson, Meriden  
 Executive Secretary Creighton Barker, New Haven  
 Editor of the JOURNAL Stanley B. Weld, Hartford

ONE DELEGATE AND ONE ALTERNATE TO THE AMERICAN MEDICAL ASSOCIATION—for the term July 1, 1947 to June 30, 1949

Thomas P. Murdock, Meriden

Alternate: Francis G. Blake, New Haven

PROGRAM COMMITTEE: A member for a term of three years—Maurice T. Root, Hartford—so that the Committee will consist of:

Samuel C. Harvey, New Haven, *Chairman*

Carl E. Johnson, New Haven

Maurice T. Root, Hartford

Associate Member: John F. Fulton, New Haven

JOURNAL EDITORIAL BOARD: A member for a term of four years—Lee D. Van Antwerp, Meriden—so that the Board will consist of:

Frank S. Jones, Hartford

Herbert Thoms, New Haven

Paul P. Swett, Bloomfield

Stanley B. Weld, Hartford

Lee D. Van Antwerp, Meriden

Associate Member: Harold S. Burr, New Haven

### COMMITTEE ON CLINICAL CONGRESS

Francis G. Blake, New Haven, *Chairman*

Herbert Thoms, New Haven, *Secretary*

Cole B. Gibson, Meriden, *Treasurer*

And such other members as the Chairman of the Committee may appoint

### COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Fairfield County, Charles H. Sprague, Bridgeport

Hartford County, Benjamin B. Robbins, Bristol

Litchfield County, W. Bradford Walker, Cornwall

Middlesex County, Richard H. Grant, Cromwell

New Haven County, Charles T. Flynn, New Haven

New London County, Edmund L. Douglass, Groton, *Chairman*

Tolland County, Leonard W. Levine, Ellington

Windham County, Brae Rafferty, Willimantic

President of the Society

Executive Secretary of the Society

COMMITTEE ON HONORARY MEMBERS AND DEGREES: A member for a term of three years—Cole B. Gibson, Meriden—so that the Committee will consist of:

H. Gildersleeve Jarvis, Hartford, *Chairman*

Joseph H. Howard, Bridgeport

Cole B. Gibson, Meriden

COMMITTEE ON MEDICAL EXAMINATION AND MEDICAL EDUCATION: A nomination to the Connecticut Medical Examining Board for a term of five years commencing January 1, 1948—Louis P. Hastings, Hartford—so that the Board will consist of:

Thomas P. Murdock, Meriden

John D. Booth, Danbury

George M. Smith, New Haven

Wilmot C. Townsend, Hartford

Louis P. Hastings, Hartford

### COMMITTEE ON TUMOR STUDY

Averill A. Liebow, New Haven, *Chairman*

Robert R. Agnew, Norwich

Irving B. Akerson, Bridgeport

John D. Booth, Danbury

Donald A. Bristoll, New Britain

Willard E. Buckley, Middletown

Gerard M. Chartier, Danielson

Harold M. Clark, New Britain

Joseph O. Collins, Waterbury

A. Nowell Creadick, New Haven

Thomas J. Danaher, Torrington

Edward W. Foster, Meriden

Carl C. Harvey, Middletown

Louis P. Hastings, Hartford

Joseph H. Howard, Bridgeport

Rolf E. Katzenstein, Meriden

Russell A. Keddy, Stamford

Ralph E. Kendall, Hartford

Kenneth K. Kinney, Willimantic

Gustaf E. Lindskog, New Haven

John A. McCreery, Greenwich

Philip G. McLellan, Hartford

Christie E. McLeod, Middletown

William Mendelsohn, New Haven

Lincoln Oppen, Torrington

Edward J. Ottenheimer, Willimantic

Berkley M. Parmelee, Bridgeport

Karl T. Phillips, Putnam

Douglas J. Roberts, Hartford

Allan J. Ryan, Meriden

Louis G. Simon, Norwalk

E. Myles Standish, Hartford

Herbert Thoms, New Haven

Frank Turchik, Bridgeport

Donald B. Wells, Hartford

State Commissioner of Health

COMMITTEE ON NATIONAL LEGISLATION: to serve for a term of one year:

Oliver L. Stringfield, Stamford, *Chairman*

Benedict R. Harris, New Haven

Ralph M. Tovell, Hartford

Chairman, Committee on Public Relations

Chairman, Committee on Public Policy and Legislation

Delegates to the American Medical Association



COMMITTEE ON HOSPITALS: Two members for a term of three years—Harold W. Wellington, New London, and Albert W. Snoke, New Haven—so that the Committee will consist of:

Robert R. Nesbitt, New Haven, *Chairman*  
William H. Curley, Bridgeport  
James C. Fox, Hartford  
Louis P. Hastings, Hartford  
Albert W. Snoke, New Haven  
Harold W. Wellington, New London

COMMITTEE ON PUBLIC HEALTH

Howard S. Colwell, New Haven, *Chairman*  
John W. Buckley, Bridgeport  
Donald A. Bristoll, New Britain  
Clair B. Crampton, Middletown  
Gilbert R. Hubert, Torrington  
Alfred Labensky, New London  
Joseph I. Linde, New Haven  
William H. McMahon, South Norwalk  
L. Rogers Morse, Hartford  
Luther K. Musselman, New Haven  
Karl T. Phillips, Putnam  
J. Harold Root, Waterbury  
Maurice J. Strauss, New Haven  
Oliver L. Stringfield, Stamford  
Alfred B. Sundquist, Manchester  
Carl L. Thenebe, Hartford

Associate Member: Friend L. Mickle, Hartford

COMMITTEE ON PUBLIC RELATIONS

C. Charles Burlingame, Hartford, *Chairman*  
Howard S. Colwell, New Haven  
Edwin R. Connors, Bridgeport  
Thomas J. Danaher, Torrington  
George H. Gildersleeve, Norwich  
Averill A. Liebow, New Haven  
Brae Rafferty, Willimantic  
C. Frederick Yeager, Bridgeport

Associate Member: Howard W. Haggard, New Haven

COMMITTEE ON INDUSTRIAL HEALTH

C. Frederick Yeager, Bridgeport, *Chairman*  
Preston N. Barton, Bristol  
Harold A. Bergendahl, Norwich  
Ronald F. Buchan, New Haven  
Gerard M. Chartier, Danielson  
Bernard S. Dignam, Thompsonville  
George G. Fawcett, South Norwalk  
John N. Gallivan, East Hartford  
Albert S. Gray, Hartford  
Martin I. Hall, Bristol  
Reinhold F. Hertzberg, Stamford  
Richard J. Hinchey, Waterbury  
Andrew J. Jackson, Waterbury  
John F. Kilgus, Litchfield  
Robert P. Knapp, Manchester  
Arthur B. Landry, Hartford  
Eugene F. Meschter, Stamford  
Philip J. Moorad, New Britain  
Frank T. Oberg, Bridgeport  
Israel S. Otis, Meriden

Crit Pharris, East Hartford  
Arthur A. Tower, Meriden  
Paul W. Vestal, New Haven  
Ellwood C. Weise, Bridgeport

DELEGATES TO STATE SOCIETIES AND SPECIAL SOCIETIES FOR THE TERM OF JULY 1, 1947 TO JUNE 30, 1948

Maine:

Stanley B. Weld, Hartford  
Orville F. Rogers, New Haven

Massachusetts:

William J. German, New Haven  
Robert A. Goodell, Hartford

New Hampshire:

W. Holbrook Lowell, Hartford  
George H. Gildersleeve, Norwich

New Jersey:

George A. Buckhout, Bridgeport  
Oliver L. Stringfield, Stamford

New York:

James R. Miller, Hartford  
Cole B. Gibson, Meriden

Rhode Island:

Robert H. Henkle, New London  
William J. H. Fischer, Milford

Vermont:

Albert C. Freeman, Norwich  
Orpheus J. Bizzozero, Waterbury

SPECIAL SOCIETIES

Connecticut Hospital Association:

Robert R. Nesbitt, New Haven

Connecticut Pharmaceutical Association:

William T. Salter, New Haven

Connecticut State Dental Association:

President of the Society

## Committees Appointed by the Council Not Requiring Election by the House of Delegates

COMMITTEE ON COOPERATION WITH YALE SCHOOL OF MEDICINE

Chairman of the Council  
President of the Connecticut Medical Examining Board  
Chairman of the Committee on Public Policy and Legislation  
James R. Miller, Hartford  
Herbert Thoms, New Haven

CONFERENCE COMMITTEE WITH CONNECTICUT PHARMACEUTICAL ASSOCIATION

William T. Salter, New Haven, *Chairman*  
Burdette J. Buck, Hartford  
Barnett Greenhouse, New Haven  
Allan K. Poole, New Haven  
William B. Smith, Hartford

## COMMITTEE ON DRUG ADDICTION

John H. Foster, Waterbury, *Chairman*  
 Edward L. Brennan, Hartford  
 Arthur H. Jackson, Washington  
 Alfred Labensky, New London  
 Edgar C. Yerbury, Middletown

Associate Member: Howard W. Haggard, New Haven

## BOARD OF TRUSTEES OF THE BUILDING FUND

James Douglas Gold, Bridgeport, *Chairman*  
 C. Charles Burlingame, Hartford  
 George M. Smith, New Haven  
 Ralph W. Nichols, New Haven  
 Vacancy

## COMMITTEE ON PREPAID MEDICAL SERVICE

James R. Miller, Hartford, *Chairman*  
 Thomas P. Murdock, Meriden  
 Cole B. Gibson, Meriden  
 Herbert Thoms, New Haven  
 Joseph H. Howard, Bridgeport

## ADVISORY COMMITTEE TO WOMAN'S AUXILIARY

Ralph L. Gilman, Storrs, *Chairman*  
 John D. Booth, Danbury  
 Barnett P. Freedman, New Haven  
 James D. Gold, Bridgeport  
 Frederick B. Hartman, New London  
 Harry F. Pennington, Meriden  
 E. Myles Standish, Hartford

## Special Committees Appointed by the Council

## COMMITTEE ON STATE-WIDE BLOOD AND PLASMA BANK

Ralph E. Kendall, Hartford, *Chairman*  
 Irving B. Akerson, Bridgeport  
 Arthur J. Geiger, New Haven  
 Averill A. Liebow, New Haven  
 Karl T. Phillips, Putnam  
 Donald B. Wells, Hartford

## SPECIAL COMMITTEE ON RADIOLOGICAL PRACTICE IN HOSPITALS

Ralph T. Ogden, Hartford, *Chairman*  
 Berkley M. Parmelee, Bridgeport  
 Hugh M. Wilson, New Haven

## COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, Derby, *Chairman*  
 Egbert M. Andrews, Hartford  
 Norton Canfield, New Haven  
 Joseph N. D'Esopo, New Haven

## COMMITTEE ON HEALTH AND PHYSICAL EDUCATION

Joseph L. Hetzel, Waterbury, *Chairman*  
 Paul Harper, Bridgeport  
 Derick A. January, Hartford  
 Frank S. Jones, Hartford  
 Joseph I. Linde, New Haven  
 Katherine S. Quinn, Bridgeport

Robert P. Rogers, Greenwich  
 James M. Sturtevant, New London  
 Carl L. Thenebe, Hartford  
 Edward T. Wakeman, New Haven

Associate Member: Ira V. Hiscock, New Haven

## COMMITTEE ON RURAL MEDICAL SERVICE

Norman H. Gardner, Easthampton, *Chairman*  
 David H. Bates, Putnam  
 James F. Ferguson, Wallingford  
 Gaert S. Gudernatch, Sharon  
 William H. Upson, Suffield

## COMMITTEE REPRESENTING SOCIETY ON BOARD OF CONNECTICUT HOSPITAL SERVICE

Arthur B. Landry, Hartford  
 William C. McGuire, New Haven  
 Ralph T. Ogden, Hartford

## ADVISORY COMMITTEE TO THE STATE BOARD OF NURSING

James C. Fox, Hartford  
 Hartwell G. Thompson, Hartford

## REPRESENTATIVES TO THE NEW ENGLAND POST-GRADUATE ASSEMBLY

Cole B. Gibson, Meriden  
 Stanley B. Weld, Hartford

## DELEGATES TO THE COUNCIL OF NEW ENGLAND STATE MEDICAL SOCIETIES

Cole B. Gibson, Meriden  
 Harold E. Speight, Middletown  
 Joseph H. Howard, Bridgeport

## COMMITTEE ON MILITARY HISTORY OF THE SOCIETY

Ralph Gilman, Storrs, *Chairman*  
 Norton Canfield, New Haven  
 Clair B. Crampton, Middletown  
 James C. Fox, Hartford  
 Louis F. Middlebrook, Jr., Hartford  
 Ralph M. Tovell, Hartford  
 Ira V. Hiscock, New Haven

## COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

Joseph H. Howard, Bridgeport, *Chairman*  
 Eric H. Blank, New London  
 Carl E. Johnson, New Haven  
 Norman C. Margolius, Waterbury  
 Charles H. Peckham, Manchester

## COMMITTEE TO STUDY WORKMEN'S COMPENSATION LAWS

John F. Kilgus, Litchfield  
 Clarence H. Cole, Waterbury  
 Thomas Soltz, New London  
 Ettore F. Carniglia, Hartford

## ADVISORY COMMITTEE TO PUBLIC WELFARE COUNCIL

Theodore S. Evans, New Haven  
 David Gaberman, Hartford  
 Alfred Labensky, New London  
 James R. Miller, Hartford  
 D. C. Y. Moore, Manchester  
 Cris Neuswanger, Waterbury



## The American Legion Consults Medicine

In the midst of the worst snow storm our Nation's Capitol had experienced in years, the medical advisors of the American Legion gathered together in February from nearly all of the forty-eight states for a three day conference. Only a few months before the Legion at its annual convention passed a resolution disapproving compulsory health insurance. By creating a medical advisor in each state, in the District of Columbia and in Hawaii, the Legion is seeking wise and expert guidance in its medical program for the veteran. Connecticut was represented by one of the editors of the JOURNAL.

The Surgeons General of the Army and the Navy and the Deputy Surgeon General of the Public Health Service outlined the medical planning and research programs of their respective organizations. The problem of the 40,000 World War II veterans who had developed rheumatic heart disease was emphasized. To aid in the great nationwide program of the American Heart Association the American Legion has contributed generously to the amount of \$50,000. The Legion is now engaged in raising funds for the establishment of a Research Professorship in Perpetuity at the University of Minnesota Variety Club of the Northwest Heart Hospital. Just whether heredity or environment determines the occurrences of rheumatic heart disease is one of the problems needing solution.

The need of mental hygiene clinics to reach the large number of psychoneurotics among World War II veterans is appreciated by the Veterans Administration. The existing neuropsychiatric hospitals are to be expanded to include general medical and surgical wards. New hospitals under construction or to be constructed will be general medical hospitals with units for all, neuropsychiatric, tuberculous, etc. New hospitals will have open and closed wards for neuropsychiatric patients and a convalescent center for every kind of medical rehabilitation and psychiatric therapy in a non medical atmosphere.

Streptomycin is being used in VA hospitals for primary tuberculosis and tuberculous meningitis with very satisfactory results. Most of the cases of tuberculous sinus tracts have closed under streptomycin therapy. The drug has its toxic manifestations, vertigo and deafness, which precludes its being turned loose for general consumption. Nineteen VA hospitals are now engaged in the study of the use of streptomycin in tuberculosis.

All should be familiar with the excellent job the dean's committee of VA has done in establishing the residency system. At present there are in the VA hospitals 1,485 residents, 850 attending physicians in the various specialties, and 700 consultants. All this has come to pass in a little over one year.

The care of the veteran in his home has been set up in almost every state in the Union. VA has made contracts with 38 state medical societies, including District of Columbia and Hawaii, in one of three forms: first, through a contract with an intermediary organization as in Michigan through the Michigan Medical Service; second, through an agreement rather than a contract with a state medical society where the physician is paid direct, as in Kansas; third, in one instance only through a contract with a county medical society for pension examinations only rather than for treatment. Connecticut operates under the second plan where the physician is paid direct by VA.

The hospital construction program is a terrific one to contemplate. \$772,702,814 has been appropriated by Congress for the construction of 74 new hospitals to furnish 39,622 additional beds. In addition 16 more hospitals with 13,400 beds have been authorized by the President but for which no funds are yet available. Thirty-one military and other hospitals have been transferred to VA and are in operation. Except for so-called feeder hospitals, these new buildings will be erected in large centers near medical schools or other sources of medical personnel of the finest quality.

General Hawley is determined the veteran shall receive the best in medical care and in that the American Legion wholeheartedly supports him. He was at his very best the second evening of the conference at the dinner tendered the medical advisors by the Legion. He urged extension of controversial Public Law 293 which wiped out civil service status from numerous VA medical positions, citing difficulties of obtaining competent personnel under civil service restrictions. General Hawley pledged that as long as he remained VA medical director, the "best possible" medical service will be available to all veterans. "The only individual who has a vested right to anything," he said, "is the patient—and that will remain so as long as I have anything to do with it." "Any medical service ceases to be a good medical service," he said, "when the rights of the employers are placed before the rights of the patient."

The National Medical Advisory Board is headed

by Dr. Leonard G. Rowntree and comprises such prominent physicians as Drs. Charles W. Mayo, George F. Lull, Waltman Walters, Winifred Overholser and Howard A. Rusk. Upon its recommendation a voluntary nationwide medical advisory service was created for the American Legion, through the appointment of a medical advisor for each Department and a surgeon for each Post. It is the function of the National Medical Advisory Board and the Department Medical Advisors to encourage, stimulate and recommend improvement of all health services to members of the Armed Forces, to study veterans' health problems, to advise and assist in health legislation under consideration by the Legion, to furnish medical guidance to the Legion, and to encourage medical research in disease and conditions as they affect the veteran, his family, and through them the general public.

Giving up three days of one's time to obtain a better understanding of the Veterans Administration's medical program in order that the American Legion may have wise guidance has its compensations. One of these is the realization of the satisfaction of the medical profession today in seeing a man of Paul Hawley's calibre and ideals carrying the torch. Another is the realization that, despite its errors of policy and political log rolling following World War I, the American Legion following the recent war is sincerely attempting to aid the veteran in a wise and mature manner. Not the least of the personal pleasures resulting from this journey to Washington was the opportunity to renew a friendship which had been hibernating since a certain spring day in 1919. Humorous events always enliven such a visit. This time the editor was mistaken for the Nation's Chief Executive.

Peripateticus

### Voluntary Plans at New High in California

*Insurance Economic Surveys* tells us that as of January 23—seven weeks after the inception of the California unemployment disability act—3,282 voluntary plans covering a total of 326,000 employees had been approved and placed in operation. 1,204 voluntary plans, covering an additional 91,387 employees are in process of approval by the Commission. The results of the success of voluntary plans in this short period far exceed the expectations of the Commission. It is predicted that in the first year of operation voluntary plans will cover at least 40 per cent of the eligible workers.

### National Conference on Rural Health Chicago, February 7 and 8, 1947

Rural health problems were discussed by several authorities of the recent annual National Conference on Rural Health, held in Chicago on February 7 and 8. In discussing the question, "Is There a Need for Improved Medical Care in Rural Areas," Dr. A. C. Backmeyer said that, according to a 1940 census, from between 19 and 20 million people lived in the open country. In over 11,171 of these communities having less than 1,000 population, there were only 151 hospitals and 85 per cent of these hospitals had less than a 50-bed capacity. In the open country outside of all villages, there were only 90 hospitals in the United States. Over 50 per cent of these hospitals had less than a 50-bed capacity, and most were special-type institutions provided for special purposes. The reason Dr. Backmeyer gave for emphasizing the need for hospitals having a minimum of 50 beds was that this number was found by the Commission on Health Care to be the least with which a hospital could be operated economically yet adequately. Less bed capacity usually means both an inadequate staff and inadequate facilities. *Therefore*, it was established that better medical care was needed for the people in rural areas.

In answering the question, "What Is Being Done Towards Improving the Condition," Dr. A. B. Wilson of the U. S. Public Health Service first explained the Hill-Burton bill, now Public Law No. 725, which provides 75 million dollars per year for the construction of hospitals and health centers. Dr. Wilson stated that these federal funds would be administered through official state agencies to local communities in order to assist the latter to meet their needs in this field. The bill has as one of its purposes the provision of means for getting an international hospital system. Before any funds are made available, however, each state must evolve a long-range plan based on its own individual needs, as ascertained by inventory, and have the plan approved by the Surgeon-General. Senator Taft was quoted that this was just what would be required—that the appropriations would be dictated by the needs of the state. And, briefly, under the terms of the bill, such an approved community project would receive federal assistance to the amount of one-third of the cost of construction and equipment, not including the cost of the site. Nothing in the bill would preclude construction of hospitals by counties, of



course, or of active voluntary groups not seeking federal aid.

It was brought out in the discussion that studies are now being undertaken in 48 states to develop plans whereby hospital service and medical care can be made more generally available in connection with the Hill-Burton bill.

In discussion "What Further Is There To Do," it was felt that there are so many improvements necessary and so much work needed. The Committee on Hospital Facilities and Health Centers believes that these needs can be handled in the execution of the 4-point program next outlined:

1. Actual formation of individual state plans now being made, so that federal appropriations may be secured.
2. A campaign to educate the population in regard to the medical situation in rural areas.
3. Concerted community action.
4. Cooperation among community groups with the state plan.

Under point 1 would appear a recommendation that an advisory committee to the state agency be appointed which would include representatives of the general public.

Point 2 includes education of the public as regards the medical facilities available, the social responsibility of that public in providing medical care, and the need for each community to take advantage of its opportunities to increase its medical facilities and hospitals. This point of the program also includes encouraging high school students to follow careers relating to public health work, and encouraging medical students to serve as general practitioners in rural areas, directly upon graduation, even in those cases where the student plans to undertake advanced studies, because such practical experience will stand him in good stead when he proceeds with his studies. Everyone should be informed concerning the provisions of the Hill-Burton bill. And hospitals should permit general practitioners to follow their patients into the hospital as far as their abilities permit. We believe that this practice would reduce the number of patients being operated upon outside the hospitals by doctors ill equipped to perform such operations but who are reluctant to give up their patients. The rural communities particularly should do all in their power to provide sufficient facilities for the local doctor so

that he is not forced to withdraw to the metropolitan areas where his practice is not thus handicapped. Above all, in the establishment of rural health centers or clinics, the preventive side of medicine, rather than the curative side, should be stressed.

Under point 3, community action, naturally falls the establishment of facilities for providing medical care. Yet even though about 20 million people live in our small towns and villages, it need not be assumed that all of these small towns must have hospitals. In order for each rural town to have a hospital, the hospital would have to be small. However, by careful planning, one large hospital could be provided to serve a large percentage of this assimilated group of people, many of them within reasonable driving distance. The danger to avoid is building a hospital that cannot be adequately supported and which, therefore, cannot render a high quality of service.

Before any rural community builds a new hospital, a careful study should be made of the local situation to determine the site and the area which the hospital is intended to serve; the number of people to be served; the amount and quality of facilities available in nearby communities; the cost of the proposed construction; the estimated cost of operation and maintenance; and the way in which the hospital would be integrated with nearby hospitals. Hospitals should be constructed only where the size of the population, the availability of medical and technical personnel, transportation and topography factors, and methods of financing the service justify the establishment and indicate continuous successful operation of such facilities. Medical service centers should be closely associated with the nearest hospital. These centers could vary from the headquarters of a nurse or a center to which a physician might go routinely, to a center having 12 beds available for emergency and obstetrical cases. If the center is composed of volunteers, they should be members of the board of the nearest hospital. In this manner, the medical profession would be brought into outlying districts on a consultation basis, the practitioner would have access to hospital facilities, and the medical profession would exercise a control over the quality of medical care in that area.

All of these three points just discussed depend for their success on the fourth, the cooperation among community groups with the state plan; for no program succeeds if it is ignored.

## *Doctor---*

### INFORM YOUR PATIENTS!

The proponents of socialized medicine have not given up. *State medicine*, with government control of medical care and everyone compulsorily insured, still threatens the American people. WE CONNECTICUT PHYSICIANS OPPOSE SOCIALIZED MEDICINE. WE BELIEVE THAT IT WILL NOT WORK.

*It has not worked in psychiatry.* For over 100 years, while other branches of medicine have progressed under the aegis of free enterprise in American medicine, 95% of the practice of psychiatry has been State medicine.

*The lack of progress in this example of State medicine is appalling.* Psychiatry contains the greatest public health problem facing the country, but in many places, appropriations of public funds have not approached the needs of even minimum decent care! Is this what your patients want in other branches of medical care?

WE CONNECTICUT PHYSICIANS BELIEVE THAT THE PROPONENTS OF SOCIALIZED MEDICINE SHOULD PROVE THAT CONDITIONS CAN BE BETTERED IN THE FIELD OF PSYCHIATRY, WHICH IS ALREADY THEIR OWN, BEFORE THEY PROPOSE GOING FARTHER ALONG THE ROAD TOWARD POLITICAL HANDLING OF MEDICAL CARE.

If Free Enterprise in American Medicine is to endure, each member of the State Medical Society must feel his public relations responsibility. If each doctor familiarizes himself with our common objectives, the good will generally entertained by the people toward individual members of the profession will be extended to include organized medicine, and the most enduring public relationship will be maintained.



## **Dr. Barker Elected President of National Conference**

Dr. Creighton Barker, executive secretary of the State Medical Society, was elected president of the National Conference on Medical Service at its 20th annual meeting in Chicago on February 9. Dr. Edward F. Sladek, of Traverse City, Michigan, was elected secretary, succeeding Dr. Barker, who held that office during the past year.

Conference members elected to the executive committee were as follows: Walter L. Burnap, Ferguson Falls, Minnesota; Edwin S. Hamilton, Kankakee, Illinois; Russell M. Kurten, Racine, Wisconsin; Joseph D. McCarthy, Omaha, Nebraska; Dwight H. Murray, Napa, California; Cleon A. Nafe, Indianapolis, Indiana; Charles L. Palmer, Pittsburgh, Pennsylvania; Britton E. Pickett, Sr., Carrizo Springs, Texas; and Walter E. Vest, Huntington, West Virginia.

## **Dr. Evans Appointed Chief of Medicine**

Theodore S. Evans, M.D., has been appointed chief of medicine of the Grace unit of the Grace-New Haven Hospital by the Board of Directors. A member of the staff for eighteen years, he succeeds Dr. Samuel J. Goldberg, Sr.

Dr. Evans, who maintains offices in 59 Trumbull Street, is an associate professor at the Yale School of Medicine, an attending physician at the Hospital of St. Raphael, a member of the American College of Physicians and is certified by the Board of Internal Medicine. He is a graduate of Yale and attended the College of Physicians and Surgeons at Columbia University.

## **Receives Citation for Army Commendation Ribbon**

A citation for the Army commendation ribbon was recently awarded by the Secretary of War to William B. Smith, M.D., of Wethersfield. The award is given in recognition of outstanding service rendered by Colonel Smith as Medical Officer of the Connecticut State Headquarters of the Selective Service System from January 1943 to October 1945. Also a veteran of World War I, Colonel Smith was recently appointed surgeon general on the military staff of Governor James L. McConaughy.

## **Dr. John Mendillo Appointed to New Haven Board of Health**

Mayor William C. Celentano of New Haven announced recently the appointment of John C. Mendillo, M.D., to serve on the Board of Health Commissioners.

Dr. Mendillo was named to serve a term which will expire on February 1, 1949. He is a native of this city and was graduated from the Yale Sheffield Scientific School in 1926 and in 1930 from the Yale Medical School. From 1930 to 1932 he interned in New Haven Hospital. He served as assistant resident in surgical pathology and bacteriology in New Haven Hospital from 1932 and 1933. From 1933 to January of 1945, Dr. Mendillo was assistant resident in surgery and gynecology, obstetrics, orthopedics and genito-urinary diseases, chest and neurosurgery in the same hospital.

He is a Davis and Geck Fellow in surgery, and during January to July of 1935 he studied in France and Italy. From July 1, 1935 and for a year he served as chief resident surgeon at New Haven Hospital and Yale University. Dr. Mendillo also holds a license to practice surgery in Florida.

He was a clinical instructor in surgery from 1935 to 1945 at Yale University.

## **Dr. Schuyler Receives Appointment as VA Chief Medical Officer**

The appointment of Dr. Samuel A. Schuyler, of New York City, as chief medical officer of the Hartford Regional Office of the Veterans Administration was recently announced by Harry T. Wood, manager.

An Army Medical corps veteran of World War II, Dr. Schuyler is a graduate of Stanford University and the University of London School of Medicine. Following internship at Harlem Hospital in New York City and a residency at Sea View Hospital, Staten Island, N. Y., he served as acting medical superintendent of the Triboro Hospital, Jamaica, L. I., and later as deputy medical administrator of Queen's General Hospital, Jamaica, L. I.

Dr. Schuyler served for 26 months in the European theater as a medical officer with the 78th Infantry Division, and as deputy chief public health officer in Bavaria with the U. S. military government. He held the rank of major.

## Dr. Solomon Resigns Post at School for Boys

Charles I. Solomon, M.D., physician and psychiatrist for the past twelve years at the Connecticut School for Boys, has announced his resignation and has opened an office for private practice in the Professional Building, on West Main Street, Meriden. He will specialize in neurology and psychiatry.

Dr. Solomon said he is continuing on an attending basis at the state school on Colony Street until his successor is selected, upon the request of Roy L. McLaughlin, superintendent.

Examination of applicants for the position will be given sometime in March, with the closing date for applications set for March 7, it was announced by Glendon A. Scoboria, state personnel director. Applicants must have five years employment experience as a practicing physician, including responsible experience in psychiatry with children or adolescents and adults, or a satisfactory equivalent combination of specialized training in psychiatry.

Dr. Solomon's service at the school, starting twelve years ago, was interrupted only during his service in the Navy, from which he emerged with the rank of commander. In private practice he will specialize in disorders of the nervous system, including problems of behavior in children.

Dr. Solomon is a graduate of the Yale School of Medicine with the Class of 1925, and did post-graduate work in neurology and psychiatry in England and Holland, and is a certified specialist in this field. He is a diplomate in the American Board of Neurology and Psychiatry. He is also a member of the American Psychiatric Association and the Connecticut Society of Neurology and Psychiatry. Dr. Solomon is an instructor in the Department of Psychiatry and Mental Hygiene at Yale School of Medicine. He served in the Navy for two and a half years and part of his service was in the ETO where he followed his specialty.

## Litchfield County Hospital Has New Superintendent

William H. Sisson has been appointed superintendent of Litchfield County Hospital to succeed Edward A. B. Willmer whose resignation takes effect March 1. Mr. Sisson has been serving as assistant administrator of the Waterbury Hospital. Mr. Willmer came here from Glens Falls, N. Y., last

## Attention!

Word has been received from the Federal narcotic agent that far too many prescriptions for narcotics are being transmitted to pharmacists by phone. This should be done only in a real emergency. Physicians are neglecting to place on narcotic prescriptions the name and address of the patient, the date, and in some cases their own signature. Both physician and pharmacist become liable for such disregard for the law.

Some physicians have adopted the practice of using printed blanks for prescriptions containing narcotics. This is an unsafe procedure with dire consequences should such blanks fall into the hands of an addict.

Your pharmacist must have your permission to refill your prescriptions which contain barbiturates. When he calls you on the phone you should appreciate his desire to be of assistance and accord him the courtesy which is his due.

summer to take over the duties of superintendent. He tendered his resignation several weeks ago because of poor health.

## Dr. Howard A. Rusk Addresses Rehabilitation Association

Lack of adequate training opportunities today hampers restoration of the disabled to useful living, Dr. Howard A. Rusk, head of the Department of Rehabilitation and Physical Medicine, New York University College of Medicine, and wartime chief of the Army Air Forces convalescent program, told more than 200 persons at the first program meeting of the newly organized Connecticut Rehabilitation Association held recently in New Haven.

Gathered in the auditorium of the Southern New England Telephone Company on Wednesday afternoon, February 26, the capacity audience heard Dr. Rusk tell of dramatic successes achieved in the Army rehabilitation program for disabled veterans, and forecast great civilian progress in this field of medicine, which he characterized as "the third phase of medical care."

"Our back bedroom and attics are full of handi-



capped people who could benefit themselves and society generally if they could obtain proper training," he declared.

He told his listeners that "whether you figure it out in dollars and cents or in terms of the humanities, it is a paying proposition," and emphasized the importance of rehabilitating workers so that they can again become employable. Industrial managements have found that when disabled persons are properly trained they can frequently perform tasks more efficiently than whole-bodied employees, he said, and pointed out that the Ford Motor Company today employs more than 11,000 incapacitated workers.

He disclosed that a recent survey conducted at New York's Bellevue Hospital indicated that 30 per cent of a test group of 1,000 discharged medical and surgical patients returned to the hospital outpatient department seeking further medical treatment when actually "these people had no further medical problems, but did have retraining problems."

An associate editor of the *New York Times*, he said that newspaper is now compiling a complete list of medical rehabilitation facilities in the United States which will soon be published in pamphlet form for the use of health and social agencies.

The speaker was introduced by Miss Gertrude Norcross, executive secretary of the Connecticut Society for Crippled Children and Adults and chairman of the association's program committee. General James M. Quinn, president of the association, and director of the Connecticut Veterans Reemployment and Advisory Commission, presided at the meeting.

The Connecticut Rehabilitation Association was organized in Hartford last October. Objectives of the organization as outlined in its constitution include the stimulation of programs of guidance, physical restoration, training and job placement for disabled persons, and affiliation with the National Rehabilitation Association. Other officers include Dr. Randall B. Hamrick, Bridgeport, vice-president, and Frederick W. Novis, Hartford, secretary-treasurer. Members of the executive committee are Carl A. Gray, president, Grenby Manufacturing Company, Plainville; Miss Gertrude Norcross, executive secretary of the Connecticut Society for Crippled Children and Adults; Charles P. Rainey, medical administrator, United States Aluminum Company, Bridgeport; and Berger E. Foss, director of the Newington Home for Crippled Children

## Dr. Moorad and Dr. Pharris Address Industrial Safety Conference

Industrial management was advised to "turn the emphasis from production to efficiency and safety," and to give increased attention to the human element as a key to achieving production goals, when the second annual Connecticut Industrial Safety Conference was held in Hartford Wednesday, March 5, at the Hotel Bond.

Dr. Philip J. Moorad, neuropsychiatrist from the New Britain General Hospital, told his audience of more than 300 representatives of Connecticut industries that to over emphasize production figures contributes to emotional tensions among workers and more frequent accidents.

He placed emotional disturbances first in the scale of causes for industrial accidents, cited studies indicating that approximately 15 per cent of the workers in most plants form an "accident-prone" class and are involved in almost 100 per cent of the accidents.

"The mentally and emotionally handicapped are greater risks than the physically handicapped," he declared, and pointed out that in many instances amputees have been discovered excellent employment risks because "they realize and accept their handicap." But he hastened to add that no one should interpret physical disability as a measure of emotional stability: "A physically disabled man who is emotionally disturbed is the worst possible risk."

Pleading for "more democracy and less class distinction in industry," the speaker elaborated on the necessity for developing a sense of cooperation and joint enterprise between workers and supervisory officials. He emphasized the importance of proper orientation and training of new employees by departmental foremen, and recommended that top-level management make it a point to personally address groups of new employees as a contribution to this process. Industry has reached a high level of perfection in machine design, with the result that factory machines are now practically fool-proof, he said, adding that further progress in production techniques must accent the qualities of proper leadership and fuller development of emotional drives.

At a meeting for industrial nurses which featured the conference, Dr. Crit Pharris, assistant medical director of the United Aircraft Corporation, predicted that considerable progress will be made in the next few years in further reducing the toll of industrial accidents.

Outlining the phenomenal progress in accident prevention which has resulted from improving machines and eliminating many types of mechanical hazards, he forecasts an important role for industrial nurses in the increasing attention which is now being given to correcting the "unsafe acts" committed by workers. He said that most accidents result from one of three main causes: (1) the employee may not be physically able to perform the task assigned; (2) he may be improperly trained; or (3) he may be simply careless.

While in the past emphasis on accident prevention has been largely directed toward the engineer and machine designer to eliminate "unsafe conditions," accent is now being placed on fuller development of the human factor and this trend is opening an entirely new field for industrial medicine, he told his audience. For this reason, he said, "the industrial nurse of today is peculiarly qualified to work in the field of accident prevention."

### Committee to Study Society Elects Officers

Dr. Courtney C. Bishop, of New Haven, was elected chairman and Dr. Frank H. Couch, of Cromwell, secretary of the Committee to Study the Organization and Objectives of the Society at its first meeting Wednesday evening, February 19, at the Graduates Club, in New Haven.

Members of the committee, appointed by Dr. Cole B. Gibson, Society president, in accordance with a resolution passed by the House of Delegates last December, were announced as follows: Fairfield County: Samuel F. Mullins, councillor, Oliver L. Stringfield; Hartford County: D. C. Y. Moore, councillor, Arthur B. Landry; Litchfield County: Floyd A. Weed, councillor, Thomas J. Danaher; Middlesex County: Harold A. Speight, councillor, Frank H. Couch; New Haven County: Herbert Thoms, councillor, Courtney C. Bishop; New London County: George C. Gildersleeve, councillor, Charles G. Barnum; Tolland County: Charles T. LaMoure, councillor, William Schneider; Windham County: Karl T. Phillips, councillor, William M. Shepard.

Dr. Gibson addressed the meeting concerning the general problems of medicine, and told members that "the Society is grateful to you who undertake this work, and there is every confidence that the pattern for the functions of the Society to be

developed by this committee will be of lasting value."

It was voted to request Dr. Gibson to continue to meet with the committee to furnish counsel and information during the study. Committee members agreed that meetings should be held at monthly intervals and that there should be no limitation of the time required to arrive at conclusions and recommendations.

### New \$100,000 Surgery Unit for Institute of Living

A new unit for psychosurgery, to be erected at a cost of \$100,000, will be built at the Institute of Living here in the spring, it is announced by Dr. C. Charles Burlingame, psychiatrist-in-chief.

The unit will be the first of its kind in psychiatry in this country, according to Dr. Walter Freeman, head of the American Board of Psychiatry and Neurology and pioneer in lobotomy.

Lobotomy will be the principal operation to be performed at the new unit, though other neurosurgery will be done also. Previously psychosurgery required at the Institute was carried out at hospitals elsewhere.

It was pointed out that an additional and important advantage will be that patients coming to the Institute for neurosurgery and particularly lobotomy, can receive postoperative rehabilitation right there also. They will not have to return to such care as their families could give them.

As Dr. Freeman said, lobotomy may relieve the emotional drive of the psychotic patient, but only by the slow course of rehabilitation, social and psychological, can he be returned to a place in society.

The new unit will be a four-story building, located south of the Institute's research building and connected with it by passageways. It will be equipped for all the specialized work of neurosurgery, and will accommodate some 20 patients for the short stays required.

The staff will include in addition to staff neurosurgeons, William B. Scoville, Richard C. Buckley, now consulting neurosurgeons for the Institute, and Joseph A. Farmer, recently from Duke University, who will be in charge of the psychiatric study for operative selection and for the immediately continuing psychological and social rehabilitation.



## Greenwich Hospital Plans New Building

The directors of the Greenwich Hospital, encouraged by the replies to its recent poll of public opinion, have concluded that immediate development of plans for expanding and modernizing the hospital is imperative if full community health protection is to be maintained.

Early in 1940, one of the three greatest needs of Greenwich was recognized to be a larger Greenwich Hospital. Since that time, demands for hospital care have risen enormously. Admissions have increased 44 per cent since 1940. Greenwich Hospital partly took care of the increased number of patients by placing beds in halls and on sun porches. Nevertheless, on one day recently, 17 more single rooms were applied for than were available. Scores of patients are on the daily waiting list. One patient stricken with internal hemorrhage could be accommodated only in the passageway to an already overcrowded ward.

Despite these growing demands, the capacity of Greenwich Hospital has remained substantially the same since 1918, although the hospital has kept abreast of the latest medical techniques, so as to benefit the greatest possible number of residents in the area it serves.

Additional living quarters for nurses were established outside the hospital during the '20's in order to release needed space for patients. The operating rooms enlarged in 1930, and sun porches were enclosed in 1932 and again in 1940. The Helen A. Thompson Memorial Clinic was opened in 1934 through the gift of Mr. and Mrs. Henry Fletcher.

Despite the intermittent additions and alterations, an overload was felt throughout the 1930's, when the hospital cared for 2,500 or more patients annually. Today, admissions of approximately 4,600 patients annually are the rule at Greenwich Hospital.

In 1940, through the generosity of Mrs. Henry W. Bagley, \$500,000 was contributed toward the construction of a larger hospital. The community matched this sum in a public campaign. Almost immediately, however, the nation mobilized for war. It became impossible to obtain materials or manpower for hospital construction. With the greatest of difficulty, an imperatively needed heating plant and laundry were pushed through to completion. With the coming of peace and the gradual lifting of restrictions on building, it became clear that for two

reasons the money at hand could not meet the community's need.

The results of the hospital's poll showed that about three out of every four residents of the Greenwich community favored a public campaign to raise the funds necessary for expanding the capacity and improving the facilities of Greenwich Hospital.

About 96 out of every 100 residents voiced the belief that hospital care offered the community should continue to meet the most advanced medical practice even though costs be increased. More than 97 per cent preferred an appeal to the public for contributions when income from patients and from all other sources fails to meet the cost of running the hospital, rather than cutting the standards of service or letting the hospital run into debt.

The building fund movement will extend over a period of more than a year, with emphasis, at the beginning, on a limited number of larger contributions. It will be concluded by general public campaign, which, it is expected, will be launched early in 1948.

No funds will be sought from June 30, 1947 to the end of October, in order to avoid conflict with the Community Chest campaign through which a large share of the hospital's free and below cost service is financed. The hospital's survey indicated that 53 per cent of the residents of Greenwich correctly realized a large share of the expense of this free and below cost care is met by the Community Chest. Eighty-eight per cent understood that rates paid by private patients are not sufficient to meet the cost of such treatment.

When the present plans take the shape of the new Greenwich Hospital, there can be no doubt that residents of the Greenwich area will have a medical center adequate to meet all requirements for full health protection, with facilities and equipment equal to any existing or being planned in other progressive far sighted communities in the country.

## Society for Crippled Children and Adults Now in Twelfth Year

Early in 1939 a small group of people met in the basement of a Bridgeport church and undertook a program to help restore the twisted limbs of several thousand crippled children.

They talked with doctors, community residents, with influential citizens and with plain citizens.

They sought the cooperation of health and social agencies, and the working or financial support of open-hearted people. The immensity of the task was frightening—but they persevered.

Before the year had run its course this determined group had initiated physiotherapy treatments for more than 250 crippled youngsters, established another clinic at Winsted, a state headquarters at Hartford, and a cooperative program with the Newington Home for Crippled Children.

This was the beginning of the statewide rehabilitation program of the Connecticut Society for Crippled Children and Adults. Organized in 1935 by a group of private citizens who understood the needs of the handicapped, the Society that year initiated its first Easter Seal campaign, raised approximately \$9,000. Last year this now familiar Easter message brought a financial response of close of \$120,000.

Forty-five per cent of these funds went into the operation of the Society's rehabilitation workshops, in Hartford, New Haven, Bridgeport, and Stamford. This is the biggest item on the budget. It means the maintenance and staffing of modern, well equipped centers where handicapped people can be trained and restored to social-economic usefulness and happier personal living.

But the workshops do not represent the full extent of the Society's efforts to aid the disabled. Through the "homebound program," which last year used 14 per cent of the budget, bedridden patients receive treatments and training by specially qualified field workers. Another activity of equal importance, that of providing medical care, education, and recreation, was allotted 15 per cent of the budget for the purchase of crutches, braces, artificial limbs, and the provision of special educational courses and recreation for crippled children who cannot attend school. Other budget distributions comprised field service, 11 per cent; National Society for Crippled Children and Adults, 8 per cent; and Easter Seal campaign expenses, 11 per cent.

This year the Easter Seal campaign opened on March 6, under the direction of Mr. John R. McComb, of Newtown. The goal is set at \$175,000, and the mailing list has been increased by 50,000 names to a total of more than 365,000. Boy Scout troops are doing their part by distributing placards for display in store windows throughout the state.

Although the public has become increasingly aware through educational programs that one of every seven persons has some degree of physical dis-

ability, the Society is still facing a public information task of considerable extent. To meet this problem its monthly news letter, "Five Star Final," is being distributed more widely than before, and publication of additional information pamphlets is being considered.

But education of the general public cannot solve every problem, Society officers point out. One of the most important features of the entire program to bring aid to the disabled child or adult is the continued and expanded cooperation of physicians in all parts of the state in referring cases to the Society's clinics. No disabled persons are admitted to any of the clinics unless they have been referred by physicians acquainted with their case.

While appreciative of the cooperation extended by practicing physicians throughout the twelve years of the Society's existence, its officers feel that the disruption of the war and the influx of new physicians into the state require a renewed approach to this feature of the program. They emphasize that quick and effective action can be taken to benefit patients referred to any of the clinics once notification by a physician has been received. Such notification may also be made directly to the Society's state headquarters at 65 Wethersfield Avenue, Hartford.

Recently, Miss Gertrude Norcross, executive secretary of the organization, announced that its goals for 1947 will include a summer camp for handicapped children, a new physiotherapy department at the New Haven Curative Workshop, more space for the Stamford Rehabilitation Workshop, and expanded programs for the Norwalk, Danbury, and Waterbury areas.

## Propose Study Home to Aid Maladjusted Children

Basing its action on numerous findings that the roots of many emotional breakdowns in adults reach back into childhood, the Connecticut Society for Mental Hygiene is sponsoring legislation for the establishment of a Child Study Home for maladjusted children in this state.

Calendered as House Bill No. 441, the legislation proposes the construction of a modern one-story building similar to a school in design at an estimated cost of \$643,000. Yearly maintenance is estimated at \$193,000, and this is requested as part of the budget allocation for the State Department of Health,



which is designed as the operating agency.

The legislation and the plans for the building were evolved by a Governor's committee appointed in 1946 to study the connection of childhood emotional disturbances with juvenile delinquency. Surveys by this committee and by other groups have disclosed that causes of juvenile delinquency, alcoholism, mental illness, and divorce are often closely connected with maladjustments arising in childhood. A survey in 1945 showed that 636 Connecticut children could have benefitted from proper treatment for maladjustments, and that half of these cases had already produced conditions requiring action by the Juvenile Court.

The committee points out that child maladjustment is not solely a problem confronting our cities, but that proportionately as many cases are found among the rural population. Since no resident care for children so afflicted exists in Connecticut at the present time, it is emphasized that this lack of treatment in the early stages of maladjustment frequently terminates in adult breakdowns requiring long-term care in mental institutions. The committee feels that proper treatment in a child study home would prevent many such cases from arising, thus saving for the state the expense of later custodial care and preserving mental health for its citizens. The bill was introduced by Mrs. Edna A. F. Edgerton, of Stamford, member of the House of Representatives, and chairman of the legislative committee on Public Welfare and Humane Institutions.

### Actions Brought by Nine Natureopaths

The issue of reciprocal agreements between Connecticut and two southern states on admitting natureopathic doctors to practice was raised again on February 11. Nine men, most of whom claimed to have been qualified in South Carolina or Tennessee, have brought mandamus actions against Health Commissioner Stanley H. Osborn, who they charged refused to grant them licenses. Dr. Osborn took the stand that reciprocity with the two states is illegal because standards there are lower.

Last June in a similar case Assistant Attorney General Harry L. Brooks charged that the state board of natureopathic examiners has been conducting a "racket" in admitting such practitioners to Connecticut.

Mr. Brooks told Common Pleas Judge Sidney A.

Johnson that he has information several diplomas have been purchased outright by individuals in Tennessee, who have never attended the schools they claimed to have attended. He said the number may run into the hundreds.

He told Judge Johnson that a case is now pending in the Supreme Court of Errors, which will determine whether Dr. Osborn must issue licenses on certification by the Natureopathic Board, regardless of whether the board has functioned legally. He believed cases pending in the Superior Court and Common Pleas Court should be held up until the Supreme Court has decided the matter.

Mr. Brooks said the situation is becoming similar to the "diploma mill" scandal of a few years ago.

### Did You Know That

The Woman's Auxiliary to the Hartford County Medical Association has an active membership of 242?

The Woman's Auxiliary to the Hartford County Medical Association held a series of teas and lectures during the past winter for the purpose of keeping its members up to the minute on State and National Medical Legislation?

The Woman's Auxiliary to the Hartford County Medical Association is attempting to increase its welfare fund in order to be able to show movies to shut-in children in Hartford County?

### Geriatrics Chapter is Organized in Waterbury

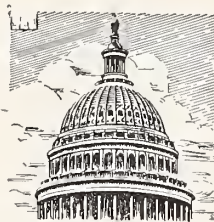
C. H. Neuswanger, M.D., and Jacques Gancher, M.D., have been named a special committee to formulate rules and regulations governing activities of the newly organized Waterbury Chapter of Geriatrics. They will submit a report at the next meeting of the chapter.

Officers of the chapter include: H. J. Stettbacher, M.D., president; O. J. Bizzozero, M.D., vice-president; Arthur F. Sullivan, M.D., secretary; John H. Dillon, M.D., treasurer.

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*Fairfield County*, Charles H. Sprague, Bridgeport  
*Hartford County*, Benjamin B. Robbins, Bristol  
*Litchfield County*, W. Bradford Walker, Cornwall  
*Middlesex County*, Frank H. Couch, Cromwell  
*New London County*, Edmund L. Douglass, *Chairman*  
 Groton

*New Haven County*, Charles T. Flynn, New Haven  
*Tolland County*, John E. Flaherty, Rockville  
*Windham County*, Brae Rafferty, Willimantic

PUBLIC  
AFFAIRSBILLS ANALYZED BY COMMITTEE ON PUBLIC POLICY AND LEGISLATION  
1947 GENERAL ASSEMBLY

## House Bills

HB24—Concerning commitment of mentally deficient adults to state training schools. Provision for the transfer of mentally deficient criminals to the Superior Court of Common Pleas and for examination and commitment by said courts.

HB26—Commitment by Juvenile Court to institutions for mentally defective. Provides for the immediate commitment of mentally defective children by the Juvenile Court.

HB33—Detention of violently mentally ill persons. Provides for the discharge or continued confinement of persons temporarily committed to mental hospitals without court order.

HB37—Provides for the study of rates in state institutions by the Public Welfare Council.

HB69—Creates a department of professional and vocational licensing consolidating 21 boards and commissions including Connecticut Medical Examining Board.

HB75—Provides for a Commission on the Care of the Criminally Insane.

HB133—Gives Alcohol Commission authority to determine commitment and support cost for persons committed for the treatment of alcoholism.

HB134—Requires that examination for commitment of insane persons be made by specialists in neurology and a diplomate of the American Board of Psychiatry and Neurology.

HB146—Directs the State Department of Health to create facilities for the processing of human blood and to distribute it for transfusion without cost.

HB175—The District Health bill.

HB327—Appropriates \$250,000 for a new building at the Newington Home for Crippled Children.

HB389—Requires a registered nurse on the staff of convalescent homes.

HB392—Removes the exclusion of massage in the Swedish method in the Medical Practice Act.

HB436—Designates the State Health Department as the agency with an advisory council to administer the Connecticut Hospital Survey and Construction Act under P.L. 725.

HB437—Provides for the licensing of hospitals and basic standards of construction and operation. Extends present law to make mandatory such licensing for hospitals seeking aid under P.L. 725.

HB441—Provides a home for the treatment and study of emotionally disturbed and maladjusted children.

HB530—Similar to HB134. Provides for examination by diplomated psychiatrists before commitment.

HB538—Provides for commitment of persons with psychopathic personalities.

HB550—Amends Medical Practice Act to give Medical Examining Board further discretion in the endorsement of licenses issued in other states.

HB555—Provides for the revocation of certificates issued by the Board of Healing Arts issued on mistake or fraudulent misrepresentation.

HB580—Increases payment from four to seven dollars a day to State Aid Hospitals for Old Age Assistance cases.

HB581—Similar to 580.

HB667—Provides a state fund of 4 per cent from motor revenues to pay for medical care and death benefits resulting from automobile accidents.

HB722—Extends the purposes and functions of the Joint Committee of State Mental Hospitals.

HB723—Creates a Joint Committee from the State Training Schools for Mental Defectives.

HB848—Creates a state fund from a two mill gas tax for the purpose of providing automobile accident and death relief.

HB862—Provides for an increase to \$25,000 as the amount of recovery possible in death actions.

HB864—Similar to HB862, but raises maximum to \$50,000.

HB910—Provides for a medical report under Workmen's Compensation to a claimant whose doctor is not present at the examination.

HB912—Provides under Workmen's Compensation Act for furnishing complete medical reports during treatment by each of attending doctors instead of a report from one doctor.

HB921—Restores Certificate of Licensure to Alexander Bothwell, D.O. (Revoked for being habitually addicted to narcotic drugs.)



HB945—Permits chiropractic practitioners to sign and file certificates of death.

HB946—Permits chiropractic practitioners to prescribe hygienic and sanitary measures.

HB947—Permits natureopathic physicians to make blood tests.

HB948—Permits chiropractic practitioners to include hygienic and sanitary measures in their practice.

HB949—Permits natureopathic physicians to sign and file death certificates.

HB953—The Birth Control bill.

HB962, 963, 964, 965—All have to do with appropriations and purposes of the Commission on the Care of the Chronically Ill and Infirm.

HB1154—Establishes a Commission to Study a State Administered Health Insurance System.

HB1155—Providing for pooled insurance tax savings to create a comprehensive social insurance protection system for all Connecticut residents.

HB1186—Creates a board of five members who shall examine all persons to be committed to state hospitals for the mentally sick.

HB1228—Under Workmen's Compensation provides medical reports by physicians hired by employers be furnished to employees and their attorneys.

HB1272—Provides for the supervision of public health nursing including school nurses of the State Department of Health.

HB1293—Places all state mental institutions and training schools for the mentally deficient under the direct supervision of the State Department of Health.

HB1294—Raises the standard of qualifications of the superintendent of the Mansfield Training School.

Senate Bills

SB15—Amends Charter of Connecticut State Medical Society to increase the value of property that the Society may hold.

SB20—Creates a temporary commission to provide facilities for the care of the criminally mentally ill.

SB21—Permits non assembled examinations for physicians

seeking employment in the State Merit System.

SB64—Provides that thyroid products shall be sold only on prescription.

SB92—Broadens the definition of personal injury under Workmen's Compensation Act.

SB121—Provides employers may obtain copies of hospital records without subpoena.

SB123—Provides a statute of limitations of five years under Workmen's Compensation Act when employee has left employment.

SB126—Restores the right to practice medicine to William S. Barnes. (Revoked for pleading guilty to committing an abortion.)

SB133—Revises Osteopathic Practice Act.

SB163—Provides that the State Department of Health shall administer the Connecticut Mental Health Program under Federal laws.

SB168—Permits Department of Health special and district laboratories.

SB173—Revises State Clinical Thermometer Standards.

SB275—Raises the limit of liability of death actions.

SB279—Increases Workmen's Compensation awards in particular cases allowing for payment of compensation for pain and suffering.

SB285—Creates a board to regulate the practice of massage.

SB291—Creates a Commission to Study the Subject of Health Insurance.

SB329—Provides tax exemption for non profit hospitals.

SB388—Concerning requirements for registration in medicine and surgery.

SB405—Provides for elimination of competition between doctors working in hospitals receiving state aid and private practitioners.

SB—640—Concerns the establishment and administration of a State System of Health Insurance.

SB685—Restores license to practice medicine to Michael J. Anthony. (Revoked years ago for fraud during eclectic scandals.)

SB742—Provides under Workmen's Compensation Act that injured employees may at all times select a physician or hospital of their choice.

THESE GAVE

CONTRIBUTORS TO THE BUILDING FUND — FEBRUARY 10 TO MARCH 10

FAIRFIELD COUNTY  
Colmers, R. A., Stamford  
Crispin, M. A., Bridgeport  
Fisher, J. G., Greenwich

FAIRFIELD COUNTY—Continued  
Harrison, F. M., Stamford  
Kaprelian, H. K., Greenwich  
NEW LONDON COUNTY  
O'Brien, J. F., Waterford

HARTFORD COUNTY  
Chester, L. L., Hartford  
Dushane, J. E., Hartford  
Wills, A. A., Jr., Hartford

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## NEWS FROM WASHINGTON

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As previously announced the Senate Committee on Expenditures in the Executive Departments held a preliminary *hearing on S140*. The authors of the bill, Senators Fulbright and Taft discussed with the Committee the need for this legislation. Senator Fulbright argued that the three departments mentioned in the bill are already combined in a single agency and he thinks their importance is such that instead of an agency, they should constitute an executive department with a secretary who would bring their activities in closer touch with the President. He admitted that there might be amendments necessary to the bill, but felt that its logic is sound. Senator Taft agreed in large measure with this statement, but argued that health was too important to be combined with welfare and education, two other important activities. He admitted, however, it would be impractical to set up three executive departments now. He called attention to the bill that he and Senator Smith and others have sponsored, S545, and expressed a preference for that bill at this time. One of the Committee questioned the wisdom of requiring that a doctor be selected to head the Health Section on the ground that doctors usually are not good administrators and the functions of the head of the Division would be largely administrative. Senator Taft defended his position by observing that the Attorney General is always a lawyer and believed that it would not be difficult for the President to find men in the medical profession with adequate administrative ability. The Committee also heard Mrs. Agnes Meyer who for several years has been advocating before congressional committees and in the public press the enactment of a similar law. The chairman announced that it was apparent that the bill is arousing a wide interest and that other hearings will be held at an early date at which time all persons wishing to be heard will be given an opportunity unless the demand is too great. Senator Fulbright announced that the American Medical Association was not prepared to endorse his bill and wished to appear before the Committee to explain its position. In this connection the Chicago office has prepared the following statement:

### BACKGROUND FOR SEPARATE NATIONAL HEALTH DEPARTMENT

An examination of the minutes of the House of Delegates of the American Medical Association shows that considerable thought was given over a period of years to the formulation of a separate federal health agency. References and records of action taken appear repeatedly in the minutes. As early as 1884 at the annual session it was urged that a separate Department of Health be established under a Cabinet officer. In 1891, a committee of twenty-three members was appointed to petition Congress on this matter. Further references appear in the minutes of the annual sessions each year from 1891 up to and including 1902. The subject apparently was not discussed during the three succeeding years, but reappears annually from 1906 to 1913, and from 1917 to 1930. After five years, a resolution was introduced into the Special Session of the House held in Chicago in 1935 urging the President of the United States to establish a separate Department of Health. At the session of the House of Delegates in San Francisco in 1938, the House adopted the following recommendation of the Reference Committee on Legislation and Public Relations: ". . . your committee recommends that this House of Delegates reiterate its demand for a federal executive department to be designated as the Department of Health, with a Doctor of Medicine at its head who shall have general supervision and direction of the affairs of the federal government pertaining to the health of the people." From the foregoing it will be seen that the American Medical Association has repeatedly gone on record as being desirous of seeing legislation passed leading to the formulation of a separate National Health Department. Current opinion in the Association at the present time is to the effect that this department should be an agency separated from other activities of the government.

Congress in 1879 passed legislation authorizing a National Board of Health. The functions and relations of this unit with other departments were very poorly defined in the law and no money was appropriated for its activities. The legislation remained



on the statute books without any action until 1893 at which time it was repealed.

It has been estimated that educators are concerned in some manner with approximately twenty-eight million members of the population. Social Security has contact with about fifty-one million people including recipients as well as taxpayers. Medicine, on the other hand, has a much broader contact and in fact, enters into the lives of all of our people.

An examination of proposals to group all health activities of the federal government under one head may be accomplished in a number of ways. The most commonly considered conceptions are:

- 1. A separate Department of Health whose head has Cabinet status.
- 2. Combining all health activities of the federal government in a separate agency not of Cabinet status.
- 3. Combining health activities with other activities of the federal government in one department.

While the American Medical Association is still of the opinion that the health of the nation warrants a separate Department of Health with a Cabinet officer at its head, it realizes that it may be impractical to develop this at the present time.

Furthermore it is its opinion that if a separate department of health is not feasible it is possible to group health activities in a separate bureau. The Association is opposed to having health activities grouped with other activities in a department with Cabinet status.

**Analysis of the National Health Bill of 1947  
Introduced February 10 — S545**

*(Prepared by the United Public Health League)*

On the same day, the Social Security Board hastily released its recommendation for a compulsory comprehensive medical care scheme. This is in line with the President's recommendation in his earlier message to the Congress.

No bill as yet has been introduced by the former advocates of Compulsory Health Insurance.

There has been very little comment in the press favoring the Taft bill, although a local Health Co-operative Group, quite leftist, did give Senator Taft's Plan its left-handed endorsement.

The revised bill, S545, follows the 1946 bill, S2143, as to the consolidation of Federal Health Agencies and appropriations for grants-in-aid to the States to provide funds for those unable to meet the

costs or part costs of medical and hospital care.

Many favorable improvements are found in S545. The principal changes are as follows

- 1. Senator Donnell as a co-author.
- 2. The appointment of a director for the Office of Medical and Hospital Care Service, who must be an M.D.
- 3. An appropriation of 3 million dollars for grants-in-aid to states for surveys of medical and hospital care needs.
- 4. An appropriation of one million dollars as grants-in-aid to the States for dental care survey. The survey appropriations are based on a matching formula for reimbursement to States similar to the plan in the Hospital Construction Act of 1946.
- 5. The elimination of the possibility of the U. S. Public Health Service taking over the program. Public Health Service is established as one of the offices of the National Health Agency.
- 6. An appropriation of 10 million dollars to Public Health Service for cancer research, control and preventive study, for grants-in-aid to the States.
- 7. Funds for the program shall be made available and deposited with the Secretary of the Treasury at the beginning of each fiscal year. This will eliminate the practice of spending money not yet available from taxing sources.
- 8. The creation of an independent agency of government for health with the director responsible only to the President and Congress.

The decision of Senator Donnell in permitting his name to be used as a co-author is most favorable. Senator Donnell, because of his active participation in the hearings last year on the Wagner-Murray-Dingell bill, is perhaps the Senator most versed in knowledge of the subject of medical and hospital care. His acquaintance with witnesses who have previously testified in this type of legislation is expected to be valuable in the hearings to follow.

**CONSOLIDATION OF HEALTH AGENCIES**

The following agencies are transferred to or incorporated in the National Health Agency: Public Health Service, St. Elizabeth's Hospital, Food and Drug Administration, Children's Bureau concerned with the administration of Title V, Part 1-2, of the Social Security Act, Division of Health Studies in the Bureau of Research and Statistics of the Social Security Administration, Office of Medical and Hospital Care Service, Office of Dental Care Service, Office of Maternal and Child Health, Office of Health Statistics.

## Review of the First Month of the 80th Session of Congress

(By the United Public Health League)

With over 1,300 Bills and Resolutions introduced during the first month, the Congress is well on its way toward pointing out the legislation pattern for 1947. While there are 35 per cent less bills introduced this session as compared to the 79th Session, there is a preponderance seeking to correct industrial unrest. Bills on all other subjects, including veterans, have decreased. Only three bills have passed both Houses during the past month. The Republican Congress is not moving as rapidly as was expected.

The Republican controlled Congress has found plenty of disagreement amongst its own leaders. The continuation of Federal excise taxes was a reversal from Republican campaign statements and number one victory for Truman.

The Knutson recommendation of 20 per cent cut across the board for income tax payers has been attacked by Republicans, much to the pleasure of the Democrats.

Congressman Engel, Michigan, said this theory of a 20 per cent tax cut would insure the re-election of the Democrats in 1948. Knutson's bill, said Engel, "is dead as an Egyptian mummy."

Senator Pepper on a new track for free medical care. This time it is the Veteran appeal, S465. A bill to provide medical care, treatment and hospitalization for dependent members of the family of any veteran of any war of the United States.

### An Interesting Bill

S199, Aiken, Vermont, establishes a national floor under current educational expenditures per pupil in average daily attendance at public schools and by assistance to non public schools of secondary grade or less, for necessary transportation of pupils, school health examinations and related school health services and purchase of non religious instructional supplies and equipment, including books. An appropriation of 400 million dollars or \$20 per pupil in average daily attendance. The amount to be increased each fiscal year until June 30, 1952, to the amount of one billion two hundred million.

The U. S. Commissioner of Education is to supervise the administration but shall not *exercise any* direction, supervision or control over the personnel, curriculum or program of instruction of any school

or system to which funds have been allocated.

The term "related school health services" means services of physicians, dental hygienists, nurses and similar health service personnel employed by the school authorities to provide prevention and diagnostic health services.

Here is a bill that is interesting because it sets a pattern by allocating funds to States and at the same time relinquishes all Federal control over our local or State school systems. Most unusual approach if we do have to enlist Federal support for education; if applicable for a plan to subsidize education, why not the same language in the Taft-Smith-Ball-Donnell 1947 National Health bill?

The allocation for Connecticut in accordance with provisions of the Taft-Ball-Smith-Donnell National Health bill of 1947 (S545) relating to medical and hospital care services for families and individuals with low income is \$1,857,600.

### 1946 Holds the Record Low Mortality

For the third year in succession the death rate in 1946 showed a decrease and set a new minimum. With this has occurred a raising of the expectation of life, more than one half year greater than in 1945. The conditions recording new lows were puerperal diseases, diseases of childhood as a group, pneumonia, diarrhea and enteritis, and appendicitis. Scarlet fever, whooping cough, and diphtheria, according to the Metropolitan Life Insurance Company's figures, recorded death rates as low as, or lower than, those for any previous year. The accident death rate dropped almost 13 per cent last year, while suicides increased 14 per cent.

### Exhibition of Yale Medical Memorabilia

During the present month there will be on exhibition in the rotunda of the Yale Medical Library interesting items concerning the early days of the Yale School of Medicine and its founders. The Medical Historical Library has selected these exhibits from its storehouse and it includes paintings, photographs, instruments, notebooks, writings and personal items. Special collections are devoted to Aeneas Munson, Benjamin Silliman, Jonathan Knight, Eli Ives, Nathan Smith and William Tully. A further viewing of material concerning the medical school may be had by visiting the Walter R. Steiner memorial on the second floor of the library.



## CONNECTICUT CANCER SOCIETY

### Campaign Dinner

Chairmen and workers from every section of the state gathered in the ballroom of Hartford's Hotel Bond to plan for the 1947 Cancer Campaign which takes place in April and will seek a goal of \$12,000,000 in the nation and \$277,440 in Connecticut.

"It can be done!" was the keynote, not just for campaign but for the fight to conquer cancer.

Harry F. Morse, State Campaign chairman and toastmaster, in a radio address over Station WTIC cited a number of diseases which a generation ago were as deadly as cancer, but for which science had found either a prevention or a cure. Among these were diphtheria, smallpox, yellow fever and others. He commented on the progress already made in Connecticut where in the past several years the rising cancer death rate has been stopped, and he called for a relentless effort until the menace of cancer is overcome.

Douglass Poteat, executive vice-president of the American Cancer Society, said "doing the impossible" was an American tradition. He told of war accomplishments in which he took part overseas prior to D-Day. He voiced his faith in the same kind of achievement to conquer a disease which killed more than war—cancer.

The guests were welcomed to Hartford by Mayor Edward N. Allen, a member of the Connecticut Cancer Society's Finance Committee. A. N. Creadick, M.D., president, opened the meeting, and the invocation was delivered by Rev. Lawrence Skelly of Waterbury, Diocesan director of hospitals. Others called upon at the speakers' table were Mrs. Douglass O. Burnham, State Field Army chairman; Dr. James Raglan Miller, chairman of the Service Committee of the American Cancer Society and trustee of the American Medical Association; J. Lawrence O'Toole, vice-president of the A.F.L. who pledged the wholehearted cooperation of its 450 locals; Dr. Philip G. McLellan, chairman of the Committee on Tumor Study of the State Medical Society, and Mrs. S. W. Caldwell and Mrs. Phyllis McPherson of the Canadian Cancer Society. A proclamation by Governor James McConaughy was read.

Mr. Morse called upon his Campaign vice-chairman, Miss Katharine Jackson of New Haven, and said that largely as a result of her work Connecticut now had all but 6 per cent of the state covered by campaign chairmen with a month to go before the drive.

Professor Ernest C. Pollard, nuclear physicist of Yale University, fascinated his audience with a demonstration of radio-active materials and how they are perceived by a Geiger Counter, the machine used to detect radio-activity at Bikini. By tracing these materials in the body, research hopes to shed new light upon the nature and therapy of cancer.

The ballroom was decorated with campaign posters brought from New York by Tod Williams of the National office. Guests received kits of sample supplies to take with them. The event was over by 10:00 P. M., and the weatherman provided a fine clear night for the drive home. General comment was that the dinner was an enjoyable and inspiring beginning for the task that from now on must take our time and thought until each community passes its 1947 goal in April.

### Many National Promotions to Aid Campaign

A complete set of American Cancer Society transcriptions and script material for live broadcasts will be delivered to every Connecticut radio station by the middle of March. The transcriptions include:

One-minute messages by Kate Smith, Jennifer Jones, LaGuardia, Ralph Bellamy, Mrs. F. D. R., Danny Kaye, Jack Dempsey and others.

Five-minute musical programs by Fred Waring, Mills brothers, Larry Adler, Jean Sablon and others.

Fifteen-minute special dramatizations by Aldrich Family, Mayor of the Town and One Man's Family.

Let your radio stations know that you will appreciate their use of these outstanding programs!

The Pharmacists of America are dedicating their week—April 20 to 26—to the cancer control program in cooperation with the American Cancer Society. The Association is contacting all its pharmacists to have cancer window displays and distribute leaflets which will be provided by the national office.

Outdoor Advertising Association of America has addressed all its members urging cooperation with the cancer campaign. Samples of the bill board have been supplied to them with a trip for sponsors at the base. Already a number of boards have been made available.

Metropolitan Life and John Hancock Mutual Life Insurance Companies have agreed to have their agents leave a mass distribution folder at the home of each family visited. These folders will be supplied by the American Cancer Society. In Connecticut alone the John Hancock Company will distribute the following amounts: Torrington 4,800; Waterbury 8,400; Stamford 5,200; Norwalk 5,000; New London 5,800; Meriden 5,800; New Britain 4,600; New Haven 11,000; Ansonia 5,000; Bridgeport 14,600; Hartford 11,000.

In the words of the national society, this "should put the prospective giver in the proper frame of mind to make a gift when asked to do so personally and directly by your local campaign committees." Hats off to the national society for these helpful promotions!

In a statement announcing that the American Cancer Society will seek to raise \$12,000,000 in this year's nationwide cancer drive, Elmer Bobst, the 1947 National chairman, disclosed that the society is financing research in 101 universities and laboratories, on which more than 1,000 scientists are at work. There are now 87 cancer detection clinics offering service throughout the country. More are springing up everywhere, he said.

Nitrogen mustard, derivative of mustard gas and a product of war research, has been effective in giving temporary relief in certain types of cancer under examination at the Hartford Hospital, according to a recent Associated Press statement. Studies are being carried out on human lymphatic tumors of a cancerous makeup.

Dr. A. N. Creadick, president of the Society, sent a letter to the Connecticut Sportswriters Alliance commending their interest in the fight against cancer. This group donated proceeds from their recent annual dinner to the Damon Runyon Memorial Cancer Fund.

In an address before the Col. Ledyard Parent-Teacher Association in New London on January 14, Dr. Matthew Griswold of the State Division of Cancer Research told his audience that examination of Egyptian mummies has shown cancer prevalent

5,000 years ago. He stressed that cancer is not hereditary or contagious.

Dr. Edward J. Ottenheimer, vice-president of the State Society, was guest speaker at the January 20 meeting of the Willimantic Woman's Club.

Former Congressman Joseph E. Talbot has accepted the appointment of district president of the Naugatuck area.

Dr. Ralph E. Kendall, member of the Society's executive committee, was the principal speaker at the recent monthly meeting of the Manchester Cancer Committee.

The need for periodic health examinations to help track down cancer was stressed by Dr. Tibor de Cholnoky at the last monthly meeting of the Greenwich Cancer Control Committee.

At a recent meeting, the Stamford Society elected Dr. Cotton Rawls, president; Miss Muriel Taylor, secretary, and Frederick J. Rathbun, treasurer. Irving Cooper repeats as campaign chairman this year.

Speedier diagnosis of tissue for possible cancer symptoms will be gained at the Lawrence Memorial Hospital in New London, where an Autotechnicon has been ordered.

## New Appointments to National Advisory Cancer Council

Appointment of two new members to serve on the National Advisory Cancer Council has been announced by Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service, Federal Security Agency. Dr. Waltman Walters, surgeon, Mayo Clinic, Rochester, Minn., and Dr. Shields Warren, assistant professor of pathology, Harvard Medical School, will fill the vacancies created by the expiration of the terms of Dr. George M. Smith, Yale University, and Dr. Sherwood Moore, Washington University, St. Louis.

Dr. Walters was first appointed to the Council in 1941, but was prevented from completing his term because of a call to duty with the Navy. He served with the rank of Captain at the Naval Hospitals in Philadelphia and in Corona, California, and later as Surgical Consultant for the Third Fleet.

Also serving as a Captain in the Navy, Dr. Warren was successively a Reserve Consultant in Pathology, Chief of the Medical Field Team of the U. S. Technical Mission to Japan, and Executive Officer



of the Naval Medical Research Section, Operation Crossroads.

The National Advisory Cancer Council acts in an advisory capacity to the National Cancer Institute, and among other duties, makes recommendations for Federal grants-in-aid to support cancer research in institutions throughout the United States. Its ex-officio chairman is the Surgeon General of the U. S. Public Health Service, and its six members are outstanding authorities in the study, diagnosis, or treatment of cancer.

### New Cancer Committee on Growth

Several Connecticut citizens are to be found on new Committee on Growth of the American Cancer Society, Inc. On the main committee is Dr. Milton C. Winternitz, professor of physiology, Yale University School of Medicine. Serving on the panel on experimental genetics will be Dr. Walter Landauer, professor of genetics, University of Connecticut; on the panel on enzymes and acting as chairman, Dr. Joseph S. Fruton, Yale University School of Medicine; on the panel on experimental endocrine physiology and acting as chairman, Dr. C. N. H. Long, Sterling professor of physiological chemistry, Yale University School of Medicine; on the panel on proteins, Dr. H. B. Vickery, biochemist in charge of laboratories, Connecticut Agriculture Experimental Station, New Haven; on the panel on chemical-biological coordination and acting as chairman, Dr. Winternitz; and on the section on clinical investigations, Dr. S. Bayne-Jones, member at large and director of the Board of Advisors, Jane Coffin Childs Memorial Fund, New Haven.

### New "Dustless" Scientifically Run Ampul Building

Winthrop Chemical Company has opened a new four-story brick and glass, windowless, germ and dust-proof laboratory plant designed to be run under constant scientific control for the preparation of injectible medicines in ampuls.

Most unusual feature is the unique system of dedusting passageways in the basement. Before entering the main building where the medicines are made, all employees and visitors must walk through one of two narrow passages lined with double dedusting blowing and suction units designed to remove lint and dust from their clothing.

### Continuous Caudal Analgesia

*Public Health Reports* for November 29, 1946 contains a statistical study of the results of delivery with continuous caudal analgesia in 2,516 women. Comparison is made with a control group of 1,024 mothers delivered under "the usual anesthetics and sedatives." Nowhere in the report is there to be found a further breakdown of just what constituted "the usual anesthetics and sedatives," except that for delivery 62 per cent received nitrous oxide and ether, 30 per cent, nitrous oxide alone, 2 per cent, ether alone, 0.4 per cent, "other" anesthetics, and 5.6 per cent, no anesthetic. Metycaine was used for continuous caudal analgesia in 99 per cent of the cases in this report. The strength of the solution is not given, neither is there reported what drug was used for the remaining one per cent. The mothers in the control group were delivered largely in the winter months, while the caudal group covered a period of 28 months, including two winters and three summers. The deliveries in both groups were all done in one large maternity hospital, the Philadelphia Lying-in Unit of the Pennsylvania Hospital.

The data reported in this series is of interest. Complete relief from pain was obtained in 90 per cent of the continuous caudal group. The mean hours of labor were somewhat lower in primiparae of the caudal group and higher in multiparae. The percentage of operative deliveries, excepting Cæsarian section, was higher in the caudal group. The third stage was shortened by almost one-third in the caudal group. One-third of this group showed a drop in systolic blood pressure during administration of the drug, however, the authors report no evidence of danger to the mothers delivered under continuous caudal analgesia.

Among the infants there was an appreciable diminution in the delay in respiration for the caudal group. The neonatal mortality and the number of stillbirths both were lower, in fact the latter group showed an improvement from 24.8 per cent in the control group to 9.1 per cent in the caudal group.

The conclusion is drawn that "if the method of continuous caudal analgesia could be applied to all deliveries in the United States with the same results as in the Philadelphia Lying-in Hospital, the present estimated loss of about 125,000 viable infants through stillbirth and death within the first week of life could be cut in half."

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## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*  
EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven  
JOSEPH N. D'ESOPPO, New Haven

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#### Hospitals For Paraplegics

Veterans Administration has established seven paraplegic centers in hospitals strategically located from coast to coast. Dr. Donald A. Covalt, chief of VA's medical rehabilitation service, said recently.

These centers, especially designated to treat veterans with spinal cord injuries which result in partial or complete paralysis of the body, are in operation in VA hospitals at: Framingham, Massachusetts; Memphis, Tennessee; Van Nuys, California; Staten Island, New York; Richmond, Virginia; Bronx, New York; Hines, Chicago, Illinois.

Because of a general shortage of doctors, physical therapists and others qualified to treat paraplegics, VA personnel skilled in this field have been assembled at the seven centrally located hospitals over the country. This will permit veterans to receive the proper treatment needed for their rehabilitation and at the same time to be as close to their homes as possible.

Until recent years, most spinal cord injury cases were doomed to a life of inactivity. In many cases, death resulted.

Today, because of modern medical science and developments in the field of physical medicine, many paraplegics are able to lead active, productive lives.

Dr. Covalt said:

"The proper medical treatment and successful rehabilitation of persons suffering from spinal cord injuries is a challenge to the medical profession. To treat each case properly, the services of the following medical team are needed: neurologist, neurosurgeon, psychiatrist, urologist, plastic surgeon, orthopedic surgeon, doctor of physical medicine, physical therapist, occupational therapist, corrective physical rehabilitation officer, educational retraining officer, pre-vocational shop supervisor, social worker and nurses."

VA has approximately 1,200 veteran-patients suffering from injuries to the spinal cord. This number is expected to reach about 2,000 eventually.

#### Veterans Administration

Veterans Administration reported on March 9 a total of 458,749 admissions of veteran patients to VA and non VA hospitals during the calendar year 1946, an increase of 174,342 or 61.3 per cent over calendar year 1945.

During the same period, beds available for the treatment of veterans in VA hospitals increased 23 per cent, from 79,450 to 97,772 and the number of hospitals increased approximately 26 per cent, from 97 to 122.

The greatest number of admissions—381,619 or 83.19 per cent of the total—were general medical and surgical patients.

Next were neuropsychiatric patients, amounting to 11.77 per cent of the total or 53,981 admissions.

Smallest group was tuberculosis patients, who numbered 19,609 or 4.27 per cent of the total.

A total of 3,540 non veteran patients, less than one per cent of all admissions, make up the difference in the figures. Non veteran admissions to VA hospitals include VA employees taken ill on the job and treated before removal to civilian hospitals; veterans of allied forces, and emergency cases admitted for temporary treatment pending removal to other hospitals.

Slightly less than 50 per cent of the total number of neuropsychiatric admissions, or 26,509 out of 53,981, were classified as psychotic cases.

The remaining 27,472 were veterans with neuropsychiatric disorders other than psychosis, such as psychoneurotics, character and behavior disorders and organic conditions of the nervous system.

Although neuropsychiatric patients in 1946 accounted for only about 12 per cent of all admissions, nearly 55 per cent of the total number of beds available in VA and non VA hospitals are generally reserved for neuropsychiatric patients, and, on any single day, VA's total patient-load includes nearly 53 per cent neuropsychiatric cases. Approximately 34 per cent of VA's beds generally are set aside for



general medical and surgical patients and about 10 per cent for tuberculosis sufferers.

The great disparity between the comparatively small number of neuropsychiatric patients admitted to hospitals, the number of beds set aside for their use and the heavy day-by-day load of such patients, results from the long periods these patients must spend in hospitals under treatment. This causes a much slower turnover in beds.

During the fiscal year 1946, neuropsychiatric patients discharged from hospitals had an average stay of 197 days, compared with 34 days for general medical and surgical patients and 186 days for tuberculosis patients.

Under present laws, veterans with service-connected disabilities have a top priority for hospitalization in VA hospitals, and in certain cases may receive treatment in non VA hospitals.

Veterans with non service-connected ailments are provided with medical care if beds are available and if they say they cannot afford to pay for treatment elsewhere. However, all emergency non service-connected cases are taken care of promptly.

## Dr. Lipkoff Appointed to Staff at Rocky Hill

C. J. Lipkoff, M.D., of Milford has been named to the surgical staff of the Rocky Hill State Veterans' hospital. He also has been serving as staff assistant at the Knickerbocker Hospital, New York. His duties in New York require a special schedule which involves commuting to Manhattan several times weekly, but he is managing to take care of his Milford patients as well as his work at the Rocky Hill hospital.

## More and More Sickness

*Insurance Economics Surveys* quotes as follows from "The War of Health Insurance" by Dr. Nathan Sinai, an advocate of a compulsory system: "The most startling thing about insurance countries is the steady and fairly rapid increase in number of days the average person is sick. In the United States, average recorded sickness per individual is seven to nine days a year. It is nearly twice that among the insured of Great Britain and Germany and has practically doubled in both countries since inauguration of insurance. It seems to be a safe conclusion that insurance has certainly not reduced sickness."

## UNRRA Health Division Closes

The UNRRA Health Division, the largest international health organization the world has yet known, wound up its activities on 31 March 1947, after more than three years of work. During this time UNRRA has made available to the health departments of thirteen liberated countries the advice and assistance of its international health staff, and has also given medical and sanitation services to over a million men, women and children in the camps for displaced persons in the Middle East, Germany, Austria and Italy. To make this work possible it was necessary to recruit from thirty-five countries a staff totalling nearly 1,200 professional persons, including doctors, nurses, sanitary engineers, epidemiologists, nutritionists, and experts in medical supplies and hospital equipment.

Dr. Wilbur A. Sawyer, director of UNRRA's Health Division, who was formerly director of the International Health Division of the Rockefeller Foundation, feels that the results of UNRRA's health work have exceeded all expectations. Europe has gone through the first year and a half after the most widespread and devastating war in history with no major epidemics, which is a much better record than was made after the last war, and this in spite of population displacements many times as great.

For several months now, the Health Division has been handing over phases of its activity to the Interim Commission of the World Health Organization. The administration of the international sanitary conventions of 1944 was transferred on 1 December. A number of UNRRA health functions in European countries and Ethiopia, including malaria and tuberculosis control and the training of health personnel through fellowships and teaching, were turned over to the Interim Commission on 31 December. Likewise, the Health Division's activities in relation to displaced persons in Europe and the Middle East were transferred to the UNRRA Displaced Persons Division, an arrangement which should continue until the International Refugee Organization of United Nations takes over the whole displaced persons program. The China health program will be transferred on 31 March.

In order to make it possible for the Interim Commission to carry on some of UNRRA's health work pending the full establishment of the World Health Organization, UNRRA has authorized the transfer of one and one half million dollars to the Commission.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, MRS. JAMES DOUGLAS GOLD, Bridgeport  
*President-Elect*, MRS. ALFRED LABENSKY, New London  
*First Vice-President*, MRS. FREDERIC W. WERSEBE, Washington  
*Second Vice-President*, MRS. JAMES RAGLAN MILLER, Hartford

*Recording Secretary*, MRS. CHARLES W. GOFF, West Hartford  
*Corresponding Secretary*, MRS. EDWIN R. CONNORS, Bridgeport  
*Treasurer*, MRS. FRANK DiStasio, New Haven

### ANNUAL MEETING OF WOMAN'S AUXILIARY TO THE A.M.A.

Haddon Hall will be the headquarters for the Annual Meeting of the Woman's Auxiliary to the American Medical Association, which will be held in Atlantic City, New Jersey, June 9-13.

Requests for reservations should be sent immediately to Dr. Robert A. Bradley, chairman, Subcommittee on Hotels, 16 Central Pier, Atlantic City New Jersey.

The regular monthly meeting of the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society was held at the Faculty Club in New Haven on February 26. Luncheon was served at 12:30 P. M., followed by an address by Dr. Creighton Barker on the subject, "Prepaid Medical Care."

On February 18 a Program Committee meeting was held at the New Haven Country Club, called by Mrs. James R. Miller, chairman. The program for the annual meeting on April 29 was planned as follows: Speaker, Joseph I. Linde, M.D., of New Haven; his subject, "Spreading the Message of Health to the People;" this to be followed by a sound movie in color, "Danger Point," and one of the broadcast scripts of the American Medical Association entitled "More Life for You."

#### FAIRFIELD COUNTY

The postponed luncheon and business meeting of the Executive Board of the Woman's Auxiliary to the Fairfield County Medical Association was held at Mrs. William A. Geer's home in Stratford on Monday, March 10. The annual meeting will be held during the first part of April, place and date to be announced later.

#### HARTFORD COUNTY

Mrs. Paul Phelps, president, presided at the second legislative discussion held on February 4 in Hartford. Dr. Grace Mooney spoke on "Recent Developments in Legislation." Another legislative meeting was held on March 4 at which time Dr. James R. Miller spoke on "Connecticut State Legislation and the Connecticut Plan for Voluntary Insurance." A

committee is investigating the feasibility of showing movies regularly to permanently home-bound children. The annual meeting is to be held on April 1.

#### NEW HAVEN COUNTY

This county held a legislative meeting on February 24 at the New Haven City Medical Society building, with Mrs. Edith Valet Cook, State chairman of legislation, presiding. Mrs. Ralph McDonnell and Dr. Creighton Barker spoke on health bills before the General Assembly. Representatives of several social agencies were present. The annual meeting was scheduled to be held on March 27 at the Oakdale Tavern in Wallingford.

#### NEW LONDON COUNTY

Mrs. Wellington reported on their Board meeting and is planning to have a program on both New London and Norwich radio stations. Fifty dollars was voted to be given to the Dorothy Labensky Memorial.

#### LITCHFIELD COUNTY

Mrs. Polito announced the date of their annual meeting as April 15 in Torrington. Magazines are being collected to be sent to mental hospitals.

#### HYGEIA

At the suggestion of the chairman, Mrs. Katz, it was decided to print a comparison of the progress made last year and this year.

Mrs. Gardiner Russell told of the need of volunteer help in mental hospitals. It was decided to notify the County presidents of the school to train volunteers for this work and to urge members to give their time as individuals rather than as Auxiliary members.



Mrs. Edith Valet Cook, legislative chairman, distributed a list of medical bills and mentioned the need of the members to become informed on the Taft bill.

The Connecticut State Medical Society has invited the mmebers of the Woman's Auxiliary to view the exhibits at the Hamden High School after the annual meeting on April 29, and to attend the dinner of the Society at the New Haven Lawn Club at 7:00 P. M. Have your husband make your reservation with his.

THE DOCTOR'S OFFICE

Paul H. Lavietes, M.D., announces his return from military service to the practice of medicine, 340 Whitney Avenue, New Haven.

Michael Louis Gompertz, M.D., announces the opening of his office for the practice of internal medicine, 43 Trumbull Street, New Haven.

Robert H. Campbell, M.D., announces the opening of his offices at 55 North Main Street, West Hartford. Practice limited to obstetrics and gynecology.

Patrick N. Brown, M.D., has opened an office in the Johnson Block on Main Street, South Meriden.

Albert G. Siege, M.D., 121 Jackson Avenue, Stratford, has recently returned from the United States Army, in which he served as commanding officer of a technical service unit of the Surgeon General's office. He is opening his office for the practice of medicine at 2089 North Avenue, Bridgeport.

John J. Murphy, M.D., will open his office at 1617 Main Street, East Hartford, the present location of Dr. Martin McCue. A graduate of Tufts College and Tufts Medical School, Dr. Murphy served his internship at St. Francis Hospital in Hartford. He served for 31 months in the Armed Forces, 24 of which was as a medical officer during three campaigns in the Mediterranean and European Theatre of operations. Since his discharge from the Army last August he did further training at St. Francis Hospital, serving in the capacity of a resident house officer on the service of Dr. Richard C. Buckley.

Mario G. Conte, M.D., who has maintained a temporary office at 171 Wolcott Street since his return

from service with the Coast Guard, has announced that he will occupy new offices at 175 Grand Avenue, New Haven. Dr. Conte served two years as a medical officer with the Coast Guard's Third Medical District in New York.

Thomas I. Ippolito, M.D., has moved his office from Wilton to 75 West Avenue, Norwalk.

P. W. Snelling, M.D., and C. A. Tucker, M.D., will remove their office to 56 Garden Street, Hartford.

Record of Industrial Accidents for 1946

During the twelve months of 1946, 19,977 industrial accidents were reported to the Workmen's Compensation Commissioners. These accidents resulted in the loss of time beyond the shift on which the employee was engaged or loss of one day or more. An industrial injury is one that is sustained by an employee in the course of and arising out of his employment, which includes all time spent by employees in performing the work in which they are employed, together with voluntary work undertaken by them while on duty with the intention of benefiting their employer.

Of the 19,977 industrial accidents reported during 1946, 12,330 were reported in the manufacturing industries and 7,647 were reported in the non manufacturing industries. Included within the total accidents reported were 47 fatalities and 461 traumatic amputations, of which latter group 424 were in the manufacturing industries and 37 in the non manufacturing industries. The iron and steel group ranked first in the number of accidents reported by industries with the non electrical machinery services and nonferrous metals groups ranking next, in respective order. Handling objects accounted for 4,430 accidents, or approximately one-quarter of the total accidents reported by causes. The other major accident causes were falls of persons, machinery, falling objects and striking against objects. Of the 828 occupational diseases reported the primary cause was dermatosis, with silicosis ranking high. It is to be noted of the total 19,977 industrial accidents reported, both compensable and non compensable injuries were reported by the carriers and self-assureds, since at the time of reporting sufficient evidence was not available to indicate whether or not the injury was a compensable one.

## OBITUARIES

### Frederic Lewis, M.D.

1910 - 1945

Dr. Frederic Lewis of Stamford, a veteran of World War II, died October 3, 1945 at Mt. Sinai Hospital, New York City, following an operation for intestinal carcinomatosis. He was 35.

A reserve officer, he was called to duty prior to Pearl Harbor with the rank of captain. He served as a flight surgeon with the Army Air Forces and was stationed in Panama.

He was sent home for treatment, was operated on, and was apparently recovered when he retired from the Army in June, 1944.

He opened his office in Stamford in July, 1944.

Dr. Lewis, who was born in New York City, was graduated from Harvard University in 1932 with a B.A. degree, and in 1936 from Long Island Medical College with the degree of M.D. For five years he trained at various hospitals.

He was physician for the State Department, Jewish War Veterans, physician for Stamford Chapter, Jewish War Veterans, a member of the County Medical Association, an associate on the staffs of the Stamford and St. Joseph's Hospitals, and a member of the Harvard Club.

Besides his wife, Florence, he is survived by his parents, Mr. and Mrs. Lewis S. Lewis of New York City, a brother, Edward, of New York City, and a one month old daughter, Carolyn.

Interment was in Mt. Carmel Cemetery, New York City.

Solomon Friedberg, M.D.

### Warren Woden Foster, M.D.

1858 - 1945

Warren Woden Foster was born in 1858, received his M.D. from Harvard in 1882, licensed to practice medicine in 1882. He died May 3, 1945 in Washington, D. C.

He was elected a member of the Connecticut State Medical Society in May 24, 1882 and his residence was then given as Putnam. In 1884 he served as a delegate from the Connecticut State

Medical Society to the annual convention of the Maine Medical Association. In 1886 he was a delegate from Windham County to the House of Delegates of the State Medical Society, but did not attend the meeting. The year 1886 is the last year in which his name appears in the roster of members living in Connecticut. It appears at or about that time he moved to the District of Columbia where he has resided and has maintained his membership in the Connecticut State Medical Society.

Robert C. Paine, M.D.

### Provisional Mortality and Natality Data for 1946

Provisional reports just received indicate that a total of 3,260,000 births were registered in the United States in 1946, the U. S. Public Health Service, Federal Security Agency, announced recently. This figure surpasses the previous high of 2,934,860 recorded in 1943 by 11 per cent. The provisional birth rate for the past year was 23.3 per 1,000 population including the armed forces overseas, or nearly 19 per cent above the rate of 19.6 for 1945 and 8 per cent higher than the wartime peak of 21.5 for 1943. In 1943 the birth rate was the highest recorded since 1924.

The mortality record for 1946 compared favorably with that for 1945. The estimated number of deaths was 1,400,000, which is nearly the same as the final number of 1,401,719 tabulated for 1945. The provisional death rate is estimated at 10.1 per 1,000 population excluding the armed forces overseas as compared with the final rate of 10.6 for 1945. This decrease of 4.7 per cent between 1945 and 1946 is, in part, due to the increase in the population at the younger ages, which resulted from the return of several million young men from duty overseas with the armed forces.

The provisional infant mortality rate for the reporting area of 46 States and the District of Columbia was 36.1, or 3.7 per cent lower than the corresponding rate of 37.5 infant deaths per 1,000 live births for 1945. These rates have been adjusted for the changing number of births.



## SPECIAL NOTICES

### U. S. PUBLIC HEALTH GRANTS

In accordance with recommendations made recently by The National Advisory Mental Health Council, the U. S. Public Health Service announces that three types of grants may soon be available under the National Mental Health Act. These grants would provide funds for training, for research, and for community services.

The Service is now authorized to make grants to institutions offering training in psychiatry, clinical psychology, psychiatric social work and psychiatric nursing—for the purpose of improvement, expansion and inauguration of training programs in these fields. Application forms and complete information may be obtained from the Training and Standards Section, Mental Hygiene Division, U. S. Public Health Service, Washington 25, D. C.

The National Advisory Mental Health Council expects to take final action on these applications by the middle of April. Interested schools therefore are urged to make their applications.

The National Advisory Mental Health Council has authorized the U. S. Public Health Service to grant a total of not more than 600 stipends this year to graduate students of psychiatry, clinical psychology, psychiatric social work, and psychiatric nursing. The Council has suggested that the stipends be equally divided among these four fields. The annual stipends range in size from \$1,000 through \$2,400 for clinical psychologists, psychiatric social workers, psychiatric nurses and up to \$3,600 for psychiatrists, depending upon the level of training for which the applicant is eligible. These awards will be made through the institutions collaborating in this phase of the training program of the U. S. Public Health Service. The names of these institutions will be announced on or about May 1. Interested applicants are requested not to write to training centers or the U. S. Public Health Service about these stipends until the May announcement is made.

Grants for research relevant to the problems of mental health may be made upon the recommendation of the National Advisory Mental Health Council to public and private institutions and to individuals. Application forms are obtainable now from the Research Grants Division, National Institute of Health, U. S. Public Health Service, Bethesda 14, Maryland.

To assist in development of adequate mental health programs at the community level, grants-in-aid will be made to States on a matching basis. These funds are handled by the mental health authority of each State. Professional and lay people interested in specific service projects should bring their ideas to the attention of their State Mental Health Authority.

Funds to inaugurate actual operation of the programs depend on Congressional appropriations. The earliest date such funds may be available is July 1, 1947.

### ANNUAL POSTGRADUATE INSTITUTE OF PHILADELPHIA COUNTY MEDICAL SOCIETY

The Eleventh Annual Postgraduate Institute of the Philadelphia County Medical Society will be held on the Roof Garden of the Bellevue-Stratford Hotel in Philadelphia, April 15-18, 1947. The theme of the meeting will be "Symposia on Medical Progress."

Among the subjects to be covered are thyroid problems, diabetes, vitamins and hormones, intestinal disorders, kidney pathology, peripheral vascular diseases, antibiotics, hypertension, diseases of the lung, neuro-psychiatry, stomach and duodenum, allergy, skin disorders, and otolaryngological diseases. There also will be two evening meetings at the Society building on the subjects of childhood and infancy disorders, and obstetrical and gynecological problems.

There will be a complete array of technical exhibits as well as a number of interesting scientific exhibits.

The registration fee for the entire course is \$5 for non members of the Society. Out of town physicians planning to attend the meeting are urged to make their hotel reservations immediately.

For further information write to Gilson Colby Engel, M.D., director, 301 South 21st Street, Philadelphia 3, Pa.

### PHARMACOLOGICAL SEMINARS FOR APRIL 1947

April 17: Dr. James L. Gamble, department of pediatrics, Harvard Medical School. "Charts About the Kidney."

April 24: Dr. Elton L. McCawley, department of pharmacology, Yale University School of Medicine. "Central Effects of the Adrenal Cortical Hormone."

Tea at 4:00 P. M., and talk at 4:30 P. M., Room B203, Sterling Hall of Medicine, Yale University.

### NEW ENGLAND DIABETES ASSOCIATION

The first meeting of the New England Diabetes Association will be held on Wednesday, April 16, 1947 at 7:30 P. M. in the Dowling Amphitheatre, Boston City Hospital. The following clinical program will be presented.

1. Diabetes and Hyperthyroidism  
Frank N. Allan, and Rosemary Murphy, Lahey Clinic
2. The Relation Between Insulin Sensitivity and Insulin Resistance  
Francis C. Lowell, Associate Professor Medicine, Boston University
3. Diabetic Coma at the Boston City Hospital  
W. R. Ohler, Assistant Professor Medicine, Harvard Medical School
4. Renal Disease in Diabetes  
Stanley Robbins, Assistant Pathologist, Mallory Institute

A brief business meeting will follow for the purpose of election of officers and directors, and adoption of a constitution.

Physicians, surgeons, nurses, dietitians and other scientific workers interested in the problems of diabetes may apply for membership at the meeting or may write for application blanks to the Temporary Secretary, Dr. James H. Townsend, 330 Mt. Auburn Street, Cambridge, Mass.

### INDUSTRIAL HEALTH MEETINGS SCHEDULED FOR BUFFALO

A conclave of combined professional personnel in industrial health work over the entire nation will take place at the Hotel Statler, Buffalo, N. Y., April 26 through May 4, 1947.

These meetings will represent the 32nd annual gathering of the American Association of Industrial Physicians and Surgeons; the 9th annual conference of the American Conference of Governmental Industrial Hygienists; the 8th annual meeting of the American Industrial Hygiene Association; the 5th annual conference of the American Association of Industrial Nurses, and the 4th annual meeting of the American Association of Industrial Dentists.

The sessions will be replete with many new subjects of interest, including among others, round table discussions for chemists, engineers, physicians and nurses; a symposium on new problems in the developments of industrial hygiene; a discussion of state codes and industrial hygiene administration; conferences on environmental control, on particle size, and analytical procedures; clinics on fractures and traumatic surgery, including a symposium on back problems; hazards incident to the use of the atomic bomb; reports on the Bikini experiments with motion pictures; tracer chemistry in toxicological research and experience with range finding tests; progress in the teaching of industrial medicine in American medical schools; the development and administration of industrial dental clinics in various industrial groups; a panel discussion on new preventive measures in industry; a panel discussion on in-service education of the nurse in industry, and many other subjects which can be found by consulting the preliminary program.

Prominent speakers on important subjects will be featured at dinner sessions, including other events such as the Cummings Memorial Lecture and the presentation of the Knudsen Award for the Most Outstanding Contribution to Industrial Medicine during the past year.

Also available at this meeting will be the opportunity to inspect and study a splendid group of scientific and technical exhibits, with the most recent developments and medical department accessories.

Further details and a copy of the preliminary program may be secured by writing to Dr. Edward C. Holmblad, managing director of the American Association of Industrial Physicians and Surgeons, 28 East Jackson Boulevard, Chicago 4, Illinois.

All hotel reservations are made by the Housing Bureau, Buffalo Convention and Tourist Bureau, Inc., 602 Genesee Building, Buffalo, N. Y.

### ANNUAL MEETING, AMERICAN COLLEGE OF CHEST PHYSICIANS

The Thirteenth Annual Meeting of the American College of Chest Physicians is scheduled to be held at the Ambassador Hotel, Atlantic City, New Jersey, June 5 to 8. An interesting scientific program has been planned for this meeting. Prominent speakers from other countries will present papers.

The oral and written examinations for Fellowship will be held on the first day of the meeting, June 5. Applicants for Fellowship in the College who plan to take these examinations should communicate *at once* with the Executive Secretary, American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

The Convocation for new Fellows and Life Members of the College will be held on Sunday, June 8. At this time certificates will be awarded to Fellows and Life Members admitted since June 1946.

### PRIZE CONTEST ANNOUNCEMENT

The American Association of Obstetricians, Gynecologists and Abdominal Surgeons announces a foundation prize contest.

For further information write Dr. James R. Bloss, secretary, 418 Eleventh Street Huntington 1, West Virginia.

### 1947 SCHERING AWARD COMPETITION

"The Clinical Use of Androgens in The Female" has been selected as the subject for the 1947 "Schering Award" competition among medical students in the United States and Canada, according to Dr. John N. McDonnell, director of Domestic Sales and Promotion for Schering Corporation, Bloomfield, N. J. As in previous years, cash prizes of \$500, \$300 and \$200 will be given for the best manuscripts received on this subject. Three judges prominent in endocrinology will select the winning entries. Dr. Norman L. Heminway, head of the Schering Medical Service Department, is chairman of the Schering Award Committee and in charge of the competition.

The "Schering Awards" are offered annually in competition to stimulate the acquisition of further knowledge of endocrinology by medical students, as a contribution to Medicine by Schering, world's largest manufacturer of hormones.

Many students from almost a hundred medical colleges will submit their manuscripts for this year's Schering Award Contest which closes July 31, 1947. Even more widespread interest is anticipated in the 1947 "Schering Award" than in previous years.

### ARMY MEDICAL LIBRARY MICROFILM SERVICE

During the war, the Army Medical Library through its photoduplication services supplied millions of pages of microfilmed medical articles to the Armed Services and other research agencies. The principal of immediate aid direct to



the user, wherever he might be introduced a new technique to assist medical research.

This service is now generally available for civilian physicians, institutions and research workers on a cost basis. This means direct access to the library's enormous resources of medical literature.

A fee of fifty cents is charged for filming any periodical article in a single volume, regardless of length. Microfilming from monographs is furnished at fifty cents for fifty pages or fraction thereof. Photostats are also available at a charge of fifty cents per ten pages or fraction thereof. Material filmed is not for reproduction without permission of the copyright owner.

For convenience and to keep bookkeeping costs down, a coupon system has been established. Users may buy any quantity of photoduplication coupons at fifty cents each. Order blanks are available upon request. Checks should be made payable to the Treasurer of the United States, and sent to the Army Medical Library, 7th Street and Independence Avenue, S.W., Washington 25, D. C.

### DEADLINE

May 1, 1947 is the deadline for entering the \$34,000 prize art contest on the special subject of "Courage and Devotion Beyond the Call of Duty" (on the part of physicians in war and in peace). This contest is open to all M.D.'s in the Western Hemisphere. The exhibition will take place in conjunction with the A.M.A. Centennial Session at Atlantic City, June 9-13, 1947. For complete information, write or wire now to Francis H. Redewill, M.D., secretary, American Physicians Art Association, Flood Building, San Francisco, California, or to the sponsor, Mead Johnson & Company, Evansville 21, Indiana, U. S. A.

### New Medical School at University of Washington

On October 2, 1946 the University of Washington opened its medical school with an enrollment of fifty members. In this first class are four women and one Chinese student. All are residents of Washington except three from Montana, one from Michigan, one from North Dakota, and three from British Columbia. Twenty-seven are graduates of the University of Washington and twenty-three are graduates of colleges in other states or of other colleges in Washington. A list of the desirable characteristics of University of Washington Medical School graduates might well be the aim of all our embryo Doctors of Medicine.

1. You should be persons with a high sense of honesty and integrity, possessed of common sense, having developed investigative minds and with a

genuine capacity for intellectual work.

2. You should be sufficiently cultured so as to be able to mix freely with cultured people in your communities.

3. You should have the knowledge of and will to promote high standards of ethics and professional work.

4. You should understand your own emotions well enough to permit good adjustments to other people, and you should be conscious of and ready to accept your responsibilities to patients and to the public. You should, therefore, be prepared to assume positions of leadership in your communities and have clear concepts of the duties of good citizens.

5. You should have understanding and proficiency in the technics for gathering evidence essential to diagnosis and management of patients.

6. You should have a general understanding of the constitution and operation of the human organism in its environment, and a particular understanding of those influences, whether bacterial, chemical, physical or psychologic, which produce the disturbances causing diseases.

7. You should be reasonably competent in recognizing and dealing with common types of disease and of appreciating situations, in which additional advice or facilities are required.

8. You should have sufficient training in psychologic medicine to understand the patient as an individual, to judge whether his reactions to his personal problems are adequate and to help him attain a suitable adjustment if they are not.

9. You should consider it as much your duty to promote health as to care for disease, and be competent to apply the principles of preventive medicine to the community as well as to the individual. You should understand the relations of social, economic and political forces to health.

10. You should have the will to contribute to medical knowledge and to think and investigate for yourselves. You should take cognizance not only of clinical and laboratory data but of all the influences which may affect health or produce disease.

11. You should be well informed in the current medical questions of the day and have firm habits of continuing study for the purpose of advancing your own education throughout your professional lives.

## OUR NEIGHBORS

### New York

The Medical Society of the County of New York on February 26 held an open meeting for the discussion of the subject of group practice. N. L. Murray, M.D., of Summit, New Jersey, discussed the professional problems involved in the organization of a group, Mr. Arthur Soderburg, a professional consultant in group practice, discussed the business problems involved, and John B. Pastore, M.D., executive director of the Hospital Council of Greater New York, devoted his remarks to the general status of group practice including the various types now in existence. Dr. Pastore has recently made a personal survey of groups operating in various parts of the United States. This meeting was intended to serve as a forum for the information of members of the County Society who are undertaking or contemplating entering into group practice.

To fill out the unexpired term of the late Dr. Simon Flexner, Governor Dewey appointed to the State Public Health Council Dr. Louis Bauer of Hempstead, L. I., a trustee of the American Medical Association, and president of the Nassau County Medical Society. Homer Folks of Yonkers, vice-chairman of the council, was reappointed for a full six year term.

New York University College of Medicine, in co-operation with WNBC, New York, has inaugurated a series of weekly programs entitled "How's Your Health?" featuring members of the faculty as guest speakers and Dean Currier McEwen as "medical moderator." The program, heard every Saturday afternoon from 2:00 to 2:15, will originate from Dean McEwen's office at the College of Medicine and will run thirteen weeks. In the first of the programs, heard March 1, Elaine P. Ralli, associate professor of medicine and chief of the Metabolism Clinic at New York University College of Medicine, was the center of a discussion on the topic, "What to Eat and Why."

In recognition of the approaching centennial celebration of the American Medical Association, a scroll commemorating the founding meeting of the A.M.A. which was held in the buildings of the medical department of New York University, was presented to Dean Currier McEwen of the University's College of Medicine at the recent Annual

Alumni Day Dinner of the College in New York.

More than 250 alumni doctors of the College of Medicine attended the dinner and saw the scroll, commemorating the founding meeting, the National Medical Convention of May, 1846, presented by Nathan B. Van Etten, past president of the American Medical Association. Signers of the scroll were Dr. Van Etten, William Crawford White, president of the Medical Society of the County of New York, and H. M. Wertheim, president of the College of Medicine Alumni Association.

A telegram received from the Board of Trustees of the American Medical Association in conjunction with the College of Medicine's Alumni Day activities said:

Greetings to the Alumni Association of New York University College of Medicine from the American Medical Association which was conceived in the halls of your school 100 years ago. May the growth and progress of the New York University-Bellevue Medical Center be as great and significant for scientific medicine and the public health as that of the young organization whose founding you gave hospitality in 1846.

Board of Trustees, A.M.A.,  
R. L. Sensenich, Chairman

The scroll presented to Dean McEwen said: "In commemoration of the assistance and hospitality extended to the National Medical Convention, the first organizational meeting of the American Medical Association, held in May, 1846, in the Hall of the Medical Department of the University then located at Broadway and Third Street, New York City, this scroll is presented to The College of Medicine of New York University on the occasion of Alumni Day, February 22, 1947."

### N. Y.'s Blue Cross Increases Rates and Benefits

*New York Medicine* informs us that Associated Hospital Service, New York's Blue Cross Plan, will raise subscription charges to its members by about one-third beginning May 1, as the result of a rise in hospital costs amounting to approximately 40 per cent, it was announced by Louis H. Pink, president. At the same time members will be given an improved contract with greater benefits in private rooms, an increase in the allowance for maternity care from \$60 to \$80, and the inclusion of penicillin and other benefits previously granted as "dividends."

Instead of a daily cash allowance, members who



## Addressed to your women patients

In its current "See Your Doctor" advertisement Parke, Davis & Company emphasizes the importance of seeking medical counsel at the time of menopause. This educational campaign, in behalf of the medical profession, appears regularly in color in LIFE and other leading magazines.

### Some things you should know about the **menopause**

No. 203 in a series of messages from Parke, Davis & Co.  
on the importance of prompt and proper medical care.



**F**OR most women today the period of menopause, or "change of life," need cause little apprehension.

It is an established fact that most of the physical discomfort and mental strains of this time are directly traceable to the changing functions of the ovaries and other glands.

*During the past few years, medical science has learned many things about the glands, and the hormones they produce. As a result, your doctor has at his command new and successful methods of controlling the symptoms of this type of glandular imbalance.*

Hot flushes, headaches, nervous tension, mental depression, sudden gain in weight, and insomnia... your doctor can usually relieve these common menopausal symptoms.

But there are other reasons, too, why you should consult your doctor as soon as you notice any signs of the menopause.

*At this time, your body undergoes many changes. It's the time when you are most likely to have a rise in blood pressure or a tendency toward gastrointestinal disturbances.*

Also, it's important to be sure that irregular menstrual periods actually indicate the onset of the menopause rather than pregnancy, or the presence of cancer or some other disease.

**SEE YOUR DOCTOR.** He can help you avoid many physical and mental problems during the menopause. Equally important, his supervision and understanding counsel at this time is your best security for continued good health in the years to come.

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occupy private rooms will be entitled to the service benefits now available in semi-private accommodations. They will be required to pay only the difference between the hospital's charge for the room and an allowance of \$6 a day paid by Associated Hospital Service.

According to Mr. Pink, the granting of service benefits to members who occupy private rooms will be particularly advantageous to persons in the lower income brackets. "Many members in this category," he declared, "are compelled to occupy private rooms for medical reasons or because semi-private accommodations are not available at the time of their hospitalization. When the illness is simple our allowance covers the major part of the bill. But when expensive drugs, use of the operating rooms, and other special services are required the hospital charges are often much more than the member can afford to pay. The new contract will remedy this situation."

Mr. Pink declared that the increased cost of hospital service makes it more necessary than ever for people to budget against the expense. "If, in the future costs should decrease," he said, "we will continue our policy of increasing benefits or we will reduce rates."

Monthly rates for group membership will be \$1 for an individual, \$2.20 for a husband and wife, and \$2.72 for a family. The cost of non group membership will be \$1.20, \$2.50 and \$3.10, respectively.

Associated Hospital Service is one of the 87 non profit hospital-sponsored Blue Cross Plans which now serve more than 25,000,000 persons in the United States, Canada and Puerto Rico.

### Rhode Island

During 1946 the Blue Cross of Rhode Island proposed to run a supplementary plan to the medical Society's proposed low cost prepayment surgical insurance program to include doctors of osteopathy but not chiropractors. In so doing the Blue Cross would utilize the same personnel and the same common fund. This proposal was voted down by the House of Delegates of the Rhode Island Medical Society at a meeting held on January 22, 1947. In a statement issued by the Society it was said "the Society believes that it can properly be concerned only with offering a plan to cover that segment of the public who desire the services of doctors of medicine. The Society is conscious of its obligation to provide the public with the highest standards of professional competence possible. It can discharge

that obligation in the proposed plan only when the service rendered is under its jurisdiction." Following this a motion was passed by the House of Delegates to appoint a committee of five members of the Society "to study ways and means of putting into effect the Rhode Island Medical Society's proposed low cost prepaid surgical plan as of its own, or through the possibility of having private insurance companies take it over."

The Rhode Island cash sickness fund is deep in the red after but a few years of operation. Now they are talking in our neighboring State of transferring \$28,000,000 from the State Unemployment Compensation Fund to bolster up the unhappy experiment. It will be up to the Rhode Island legislature.

## NEWS

### *from County Associations*

#### Fairfield

The business meeting of the Norwalk Medical Society was held at the Norwalk Hospital, February 26. The following new members were elected from Norwalk: Martling Jones, David Rubin, Ralph Sikes, Frank Serena, Faith Ogden, Thomas Ippolito, Henry Applebaum and Harry Bradley. Also elected to membership were Leonard Maidwan of Wilton and Harry DiBlanda of Westport.

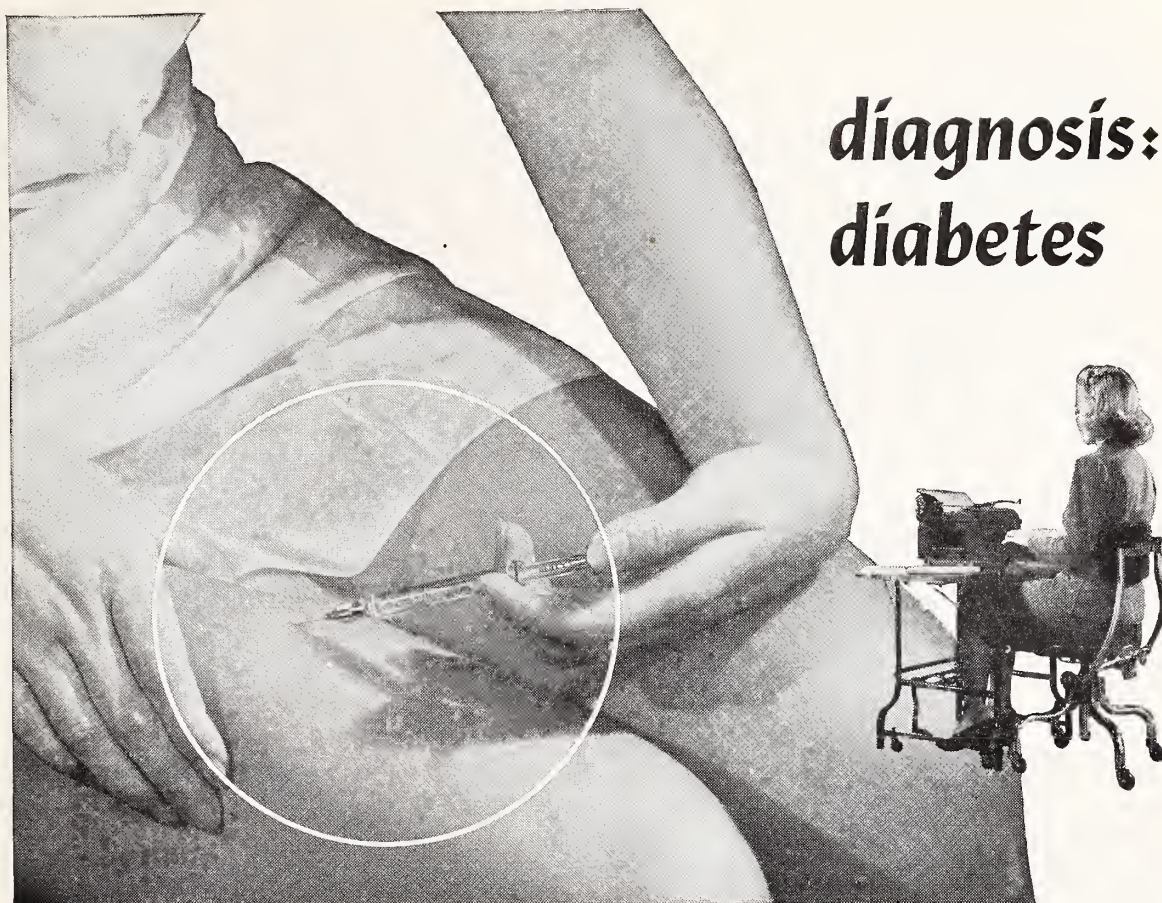
New applications for membership were received from Roger Robitaille, Norwalk; Matthew Owen Locks, Westport; and Neil Lebhar, Westport.

J. Stanley Kenney, medical director of Fordham and Lutheran Hospitals in New York, was the speaker at the monthly meeting of the Bridgeport Medical Association held at the University Club on Tuesday evening, March 4. Dr. Kenney spoke on "Rheumatic Fever," specifically the newer concept of the disease as being due to hypersensitivity. The meeting was presided over by Daniel Keegan in the absence of Charles Nichols who is spending a few weeks in Florida.

Among the members of the Bridgeport Medical Association enjoying a sojourn in Florida are Joseph Watts and B. L. Smykowski. Charles W. Gardner, chief in cardiology at Bridgeport Hospital is spending a few weeks in New Orleans; as usual Dr. Gardner, a confirmed air enthusiast, went by airplane.

The monthly meeting of the staff of Bridgeport





## diagnosis: diabetes

**T**ODAY's newly diagnosed diabetic can live a near-normal life. Most mild or moderately severe cases can be controlled with *one daily injection* of 'Wellcome' Globin Insulin with Zinc, which also allows a higher carbohydrate intake more nearly normal. The intermediate action of Globin Insulin closely parallels physiologic needs; maximum activity occurs when the patient is awake and eating, but wanes to minimize nocturnal hypoglycemia.

**INITIAL DOSAGE AND DIET:** One-half hour before breakfast administer  $2/3$  units of Globin Insulin for every gram of sugar spilled in a 24-hour urine specimen. Or start with 15 units of Globin Insulin and increase dosage every few days.

Divide the total carbohydrate allowance (140 to 240 gms.) as  $1/5$  breakfast,  $2/5$  lunch and  $2/5$  supper. (The total  $4/5$  lunch-supper allowance may be apportioned to fit the patient's requirements.) Mid-afternoon hypoglycemia may usually be offset by 10 to 20 gms. of carbohydrate between 3 and 4 p.m.

**FINAL ADJUSTMENT:** Both diet and dosage must be adjusted subsequently to meet the individual needs. Final carbohydrate distribution may be based on fractional urinalyses. Globin Insulin dosage is adjusted to provide 24-hour control as evidenced by a fasting blood sugar level of less than 150 mgm., or sugar-free urine in fasting sample.

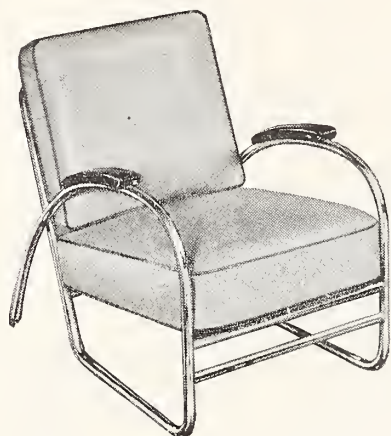
'Wellcome' Globin Insulin with Zinc is a clear solution, comparable to regular insulin in its freedom from allergenic properties. Available in 40 and 80 units per cc., vials of 10 cc. Accepted by the Council on Pharmacy and Chemistry, American Medical Association. Developed in The Wellcome Research Laboratories, Tuckahoe, New York. U.S. Patent No 2,161,198. LITERATURE ON REQUEST.

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Hospital was held on February 28, having been postponed a week because of the blizzard. A symposium on "Head Injuries" was given by W. Lee Weadon, Harold Ribner and Roger TerKuile as chairman. On February 11, Benjamin Horn, Daniel Massey, Nathan Friedman, Edwin Connors, I. Sidney Zaur and Allen Delevet, attended the lecture at the New York Academy of Medicine to hear Paul D. White of Boston, who spoke on "Recent Advances in the Treatment of Cardiac Diseases."

George Buckhout recently addressed the Lions Club in Bridgeport. Francis P. Carroll is recuperating after his recent illness at St. Vincent's Hospital. Luther and Estelle Strayer of Stratford recently attended clinics in Chicago.

Michael C. Anton, Major, MC-AUS, retired, has been appointed post surgeon of the Connecticut National Guard for the Stratford section. By this appointment Dr. Anton does not become a member of the National Guard, according to the *Stratford News*. He maintains an office at 2390 Main Street, Stratford Center, formerly occupied by the late E. J. H. Hennessey, M.D.

## Litchfield

Maurice J. Reidy, M.D., of Winsted, one of the city's most esteemed residents, died on February 13 at St. Francis Hospital in Hartford. He had been a patient there almost six weeks, after being taken suddenly ill at his home.

## Middlesex

On February 10 the Central Medical Association met and election of officers for the ensuing year resulted in Charles Russman assuming the office of president, Norman Gissler, vice-president, Norman Gardner, secretary, and Willard Buckly, treasurer. The retiring president, Richard Grant, was presented with an Eversharp C. A. pen. Harry Knight gave a paper on "Nephroptosis."

Carl Harvey has returned to the fold after a vacation of better than six weeks spent touring the country, with considerable time spent in California. He managed to ride his hobby of skiing on several occasions.

Joseph Magnano helped Mrs. Magnano celebrate their 10th wedding anniversary with a weekend in New York where they enjoyed an evening at the opera.

The final plans for the Central Medical Association Centennial are shaping up. This will be held on Wednesday, April 9, at the Club Vasques in Middletown and will consist of a dinner meeting with after-dinner addresses by Dr. Morris Fishbein and Dr. James Murphy. The latter will give a history of the Society since its inception.

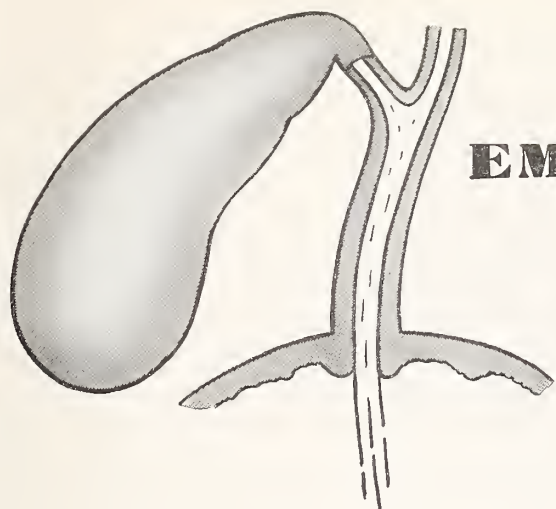
## New Haven

The Meriden Medical Society amended its by-laws recently to admit doctors in Southington and Cheshire to membership. Several other by-laws also were changed or amended by a large attendance of Meriden and Wallingford doctors. According to a statement by the president of the Society, with those admitted recently every medical man in Meriden now holds membership in the Society.

Lawrence Tierney, M.D., has been appointed medical examiner for West Haven and Arnold Rilance, M.D., for Orange.

Michael S. Shea of New Haven was elected president of the Medical Board of St. Raphael's Hospital at a meeting of the hospital staff this week. He was previously vice-president of the board and replaces





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Joseph D. Russo. Edmund J. Behan was named vice-president and Lloyd L. Maurer continues as secretary-treasurer, a three year term. Nearly 50 doctors present at the annual meeting heard reports from the various committees of the board, including a report from the hospital's newly established outpatient service, headed by William Collins. This new service, established less than a year ago, was reported to be off to a good start, with more than 1,200 visits to date.

The New Haven Medical Association held the annual 1947 meeting at headquarters, 364 Whitney Avenue, New Haven. James Gettings was elected as president. The group also heard a report by Dr. Harry Berman on "Problems on Hard-of-Hearing Cases." Dr. Berman was the past president of the Association. Other officers elected were: Harry Conte, vice-president; Clement Batelli, recording secretary; Frederick Wies, financial secretary; and Joseph Petrelli, treasurer. The following committees were also named: Executive, Drs. Gettings, Berman, and Eugene Blake; Literary, Dr. Hyman Levin; House, Drs. William Wilson and Harold Flynn;

Finance, Dr. Allan Poole.

The Post-Graduate Course on Industrial Medicine, given under the auspices of the Yale Institute of Occupational Medicine and Hygiene at the Yale University School of Medicine, started on February 4 and will continue through April 8. These meetings are held every Tuesday between 4:00 and 5:30 P. M. at the Brady Amphitheatre, entrance 310 Cedar Street, New Haven. The course is open without charge to all physicians, particularly those engaged in full time or part time industrial practice. Inquiries and reservations should be addressed to Dr. R. F. Buchan, Yale Institute of Occupational Medicine and Hygiene, 310 Cedar Street, New Haven, Conn.

On February 20 there was a meeting of the combined State Tumor Clinics at the Waterbury Hospital where several papers on cancer of the prostate and rectum were given. There were about eighty in attendance at the meeting.

A Geriatrics Society has been organized in Waterbury among members of the Waterbury Medical Society. Monthly meetings are to be held and the third meeting of the Society was held in March.

### New London

On Thursday, March 6, the annual get-together of the State Society officers with the New London County Association was held, preceded by a dinner at the Norwich Inn. The meeting at Uncas-on-the-Thames was addressed by Thomas P. Murdock, Joseph H. Howard and Creighton Barker. A most enlightening report of both federal and state matters was given and a general discussion followed with many interesting questions. At this meeting, a report of the condition of Dr. W. H. Weidman was given and everyone was pleased to learn that he is making a most satisfactory recovery following a recent illness. A resolution was passed expressing sympathy and hope for a complete and speedy recovery.

Mario J. Albamonti of Norwich spent the week of March 3 at the Knickerbocker Hospital, New York City, taking a refresher course in poliomyelitis under the direction of Dr. Philip Stimson.

Louis Guss of this city is now at the New York Post-Graduate Hospital taking a month's course in pediatrics.

### Windham

Walter Rowson, Jr., a World War II veteran who has been a resident physician in Putnam since last November with an office in Hotel Putnam, disclosed recently that he will continue his practice about March 1 in North Grosvenordale. Although it is generally agreed in Putnam that more physicians are needed, residents of the town of Thompson will be pleased to learn that the area will have the services of a qualified medical man. Since the death of the late Dr. Robert Paine no physician has been available for community service, aside from doctors in nearby communities. Dr. Rowson will occupy and maintain his office in what is familiarly called the "Mansion" in the immediate vicinity of the Community House in North Grosvenordale. He is a native of Groton, Connecticut, although he received his early education at Braintree, Massachusetts, high school and graduated from Bowdoin College where he was a member of the 1937 State championship football team. He also graduated from Yale University School of Medicine and interned at Hartford Hos-

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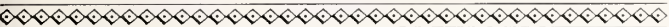
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pital before he served two years in the U. S. Army. Because of reasons of health E. J. Ottenheimer, M.D., of Windham, who had to give up his practice for the time being, is with the American Cancer Society in New York City.



## News from Yale University School of Medicine



Francis G. Blake, dean of the Yale School of Medicine and Sterling professor, was honored recently by the Department of Internal Medicine of the school at a dinner in the New Haven Lawn Club, celebrating his 60th birthday and completion of 25 years as professor. Dr. C. E. A. Winslow, emeritus professor of public health, was toastmaster. Mrs. Blake, Mr. and Mrs. F. Gilman Blake, Jr., of Cambridge, Massachusetts, Dr. and Mrs. William D. Blake of New York, John B. Blake of this city, and members of the medical faculty were present.

NEW BOOKS IN REVIEW

*MUSCLE TESTING—TECHNIQUES OF MANUAL EXAMINATION.* By Lucille Daniels, M.A., Director and Associate Professor of Physical Therapy, Stanford University; Marian Williams, M.A., Assistant Professor of Physical Therapy, Stanford University; and Catherine Worthingham, M.A., Director of Professional Education, The National Foundation for Infantile Paralysis, Inc. Designed and illustrated by Harold Black with 349 diagrammatic line drawings. Philadelphia and London: W. B. Saunders Company. 1946. 189 pp. \$2.50.

Reviewed by MAURICE M. PIKE

This small book published by the W. B. Saunders Company is the result of considerable study in the very progressive Physical Therapy Department of Stanford University, Palo Alto, California, this study being aided by a grant from The National Foundation for Infantile Paralysis, Inc.

The importance of recording spasm and contracture where they may exist is well recognized, whereas the use of gravity resistance still remains the basis for manual muscle testing to note any change in progress during treatment. The muscle examination chart approved by and supplied free of charge by the National Foundation for Infantile Paralysis, Inc., is



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illustrated. In considering the examination of the various muscles, "prime movers" are designated as those muscles mainly responsible for the completion of the full range of motion of any joints. This, of course, simplifies greatly any muscle examination. The form of presentation of all methods of examination by means of illustrated drawings from actual photographs demonstrates the effect of the considerable intensive study in audio-visual education made by both branches of the armed services in the recent war.

This book is highly recommended to all physical therapists and to physicians, particularly orthopedic surgeons, frequently called upon to make muscle examinations.

**ALLERGY IN THEORY AND PRACTICE.** By Robert A. Cooke, M.D., S.C.D., F.A.C.P., Attending Physician and Director of the Department of Allergy, the Roosevelt Hospital, New York City. Philadelphia and London: W. B. Saunders Company. 1947. 572 pp., with 43 illustrations. \$8.00.

Reviewed by GEORGE H. HURWITZ

This authoritative book by Dr. Cooke and associates is the outgrowth of courses in allergy sponsored by the American College of Physicians and is a presentation of the experience and views of "The New York Group." The writings of Dr. Cooke, one of the outstanding pioneers in allergy, have always been characterized by rational thinking, a scientific attitude, and freedom from mysticism and obscurantism. In clear, vigorous style, without verbosity, his book covers the entire field of allergy.

One of the unusual and stimulating aspects of this book, the most recent of many new texts on allergy, is its emphasis on the role of infection in allergic diseases. In the asthmatic over forty the predominant causative factor is usually infection, as Dr. Cooke brings out so strongly. He has shown how much can be accomplished in these cases by thorough elimination of upper respiratory foci of infection, especially chronic sinusitis. In support of this, there is a chapter by Dr. Grove on the nose and throat in relation to allergy, with emphasis on hyperplastic sinusitis.

The discussions on immunology, particularly on the delayed and immediate types of clinical reaction, will clarify for many the information to be expected from skin testing. Together with the chapters on the Immuno-Chemistry of Antigens and Antibodies and The Pathologic-Anatomic Aspects of Allergy, they form a firm basis for the following clinical sections.

Cooke's chapters on allergy of the skin also present a point of view different from the usual one and go a long way toward resolving the confusion and variety of opinion on this subject.

The other sections are not inferior. Pediatric allergy and allergy to foods are discussed by Chobot in an equally scientific and lucid manner. The rest of the field, such as extrinsic asthma discussed by Spain, allergic rhinitis, seasonal and perennial, by Vander Veer, Hebal, and Spain, allergy of the eye, of the digestive system and others are included to make a book which is heartily recommended as an integrated rather than an encyclopedic study of allergy.

**CARDIOVASCULAR DISEASES.** By David Scherf, M.D., F.A.C.P., Associate Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals and Linn J. Boyd, M.D., F.A.C.P., Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals. Philadelphia: J. B. Lippincott Company. 1947. 478 pp. with 56 illustrations. \$10.

Reviewed by JAMES E. CARROLL

The authors are directors of the medical department of New York Medical College, and are qualified internists. They have previously contributed much to scientific medicine in text and medical journals on the recognition and treatment of circulatory pathology. This text book represents an honest effort on behalf of medical school students, house officers, and incipient internists to portray the various methods employed in differential diagnosis. Symptomatology, pathology, physiology with modernized treatment in this broad field of cardiovascular diseases is outlined. Its presentation is unique from beginning to end. The reading is easy; it is not soporific, contains much information of every day practical value and is written in a professorial air with bedside and laboratory experience. Lending authority to the book is the certification of both men by the American Board of Internal Medicine.

There are 31 numerical headings or chapters, beginning with Dyspnea and ending with Therapy. At the conclusion of each heading is a reference bibliography of the authors' research to inform the reader further concerning any problem that may arise relative to the subject under discussion.

Their statements are basic, and the section on Treatment of Acute Coronary Thrombosis is particularly illuminating to anybody obsessed with the idea that an intravenous medicament must be introduced into a damaged circulation.

All text books are found changeable with the advent of newer concepts; however, the authors have brought this book up to date. All phases of modern entities dealing with pathology, physiology, roentgenology, and treatments of the anomalies involving the circulatory apparatus come under discussion. It is not a "must" book for all practitioners, but it speaks with considerable authority to all specialized groups interested in a source book dealing with up to date discussions on circulatory diseases. The experienced internist and cardiologist will recognize repetition but, as Osler has so aptly stated, "constant repetition makes a good habit last."

### "COURAGE AND DEVOTION BEYOND THE CALL OF DUTY"

Through the cooperation of Mead Johnson & Company \$34,000 in War Bonds are being offered to physician-artists (both in civilian and in military service) for art works best illustrating the above title, as applied to physicians in war and in peace.

This contest is open to members of the American Physicians Art Association and will be judged June 9-13, 1947, at the Atlantic City Session of the American Medical Association. For full details, write Dr. F. H. Redewill, Secretary, Flood Building, San Francisco, Cal., or Mead Johnson & Co., Evansville 21, Indiana.



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## *When Nitrogen Balance Must Be Restored*

In the correction of protein insufficiency, or in the maintenance of nitrogen balance, accumulating evidence substantiates the dictum that hydrolyzed protein substances should be employed *only* when oral feeding of protein foods is impossible or not feasible.

It has been shown experimentally<sup>1</sup> when hydrolysates of protein are injected at two different rates (1.0 and 1.5 mg. of nitrogen per Kg. of body weight per minute), the more rapid injection rate results in a higher excretion of both free amino acids and peptides. The authors ventured that even in the presence of a definite demand for protein replenishment, nitrogen excretion is mainly controlled by the kidney threshold.

In a recent survey, Ravdin<sup>2</sup> stated that "When oral feeding is used, whole foodstuffs should be given. There is no beneficence in feeding protein hydrolysates unless there is evidence of faulty digestion. Feeding of mixtures of polypeptides and amino acids may result in an absorption rate of amino acids which is more rapid than can be resynthesized by the liver, especially when the function of this organ is not normal."

When protein foods are ingested, the contained amino acids are released slowly and in a sustained manner during the course of the digestive processes. The absorptive capacity of the intestinal mucosa is not overtaxed, and maximal amino acid utilization is made possible without urinary loss.

As a source of protein, meat ranks high among the foods of man. It is 96 to 98 per cent digestible, and its protein is biologically adequate, capable of satisfying every protein need of the organism.

1. Editorial: J. Am. Dietet. A., 22:1063 (Dec.) 1946.

2. Ravdin, I.S.: Some Problems of Protein Deficiency, Connecticut M.J., 11:7 (Jan.) 1947.

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Johns Hopkins Medical School, M.D., 1911

Postgraduate study in Germany and Austria

Instructor in Clinical Obstetrics, Johns Hopkins Medical School  
and Resident at Hospital for Women of Maryland

Assistant and later Visiting Obstetrician and Gynecologist, Hart-  
ford Hospital, 1915-

Consulting Gynecologist to several Connecticut hospitals

World War 1, Captain MC; served as laboratory officer in Evacua-  
tion Hospital No. 3, A.E.F.

Fellow American College of Surgeons, Member Board Governors

Diplomate American Board Obstetrics and Gynecology

Member city, county, state and national medical societies

Member American Gynecological Society and many other obstet-  
rical and gynecological societies

Delegate to American Medical Association, 1941-1945; Trustee,  
1945-

Chairman of Committee on Medical Care and Health of Con-  
necticut Postwar Planning Board

Member Editorial Board, Standard Nomenclature of Diseases and  
of Editorial Advisory Board, Journal of Anesthesiology

Chairman Medical and Scientific Committee, American Cancer  
Society

Formerly: Physician in Chief, Hartford Dispensary

Chairman, Hartford County Chapter, National Foun-  
dation for Infantile Paralysis

Past President: New England Surgical Society

Hartford County Medical Association

Council of New England State Medical Societies

Council of Social Agencies of Hartford





## THE PRESIDENT'S PAGE

I AM DEEPLY sensible of the honor you have shown me. I trust that I may be equal to the task, and that I can carry on the traditions of my predecessors who have made a habit of unselfish and tireless service for you and for the public which you serve.

An important and able committee of the Society is at work studying the functional structure of our entire organization. This should not be hurried, but we may hope that definite suggestions will be forthcoming by the time of our next annual meeting. I am going to make one now.

Connecticut differs from many of the states in the conditions which influence its medical organization. Our county associations, with the exception of New London, meet but twice a year. Talent and enthusiasm which might be at the disposal of the county medical association is often absorbed by programs of hospital's staffs, and of city medical societies. Social responsibilities of the guild fall into the hands of a small but devoted group of men whose enthusiasm, I must confess, is often dulled by their comrades' indifference to this important part of a physician's life.

I would not suggest that all county medical associations embark forthwith on a schedule of monthly meetings. I do, however, suggest that the importance of a strong, healthy county association be borne in mind constantly by those who have charge of the development of programs for local medical society and hospital staff meetings. The capacity of physicians to attend meetings is limited.

In my own county unless April 1 falls on a Tuesday the annual meeting of the county medical association follows within twenty-four hours a meeting of the Hartford City Medical Society whose programs invariably attract a large audience. Whether a physician can afford to give up two consecutive days to medical meetings, many of them will not do so. If, therefore, the Hartford City Medical Society, whose members are equally all members of the county association, wishes to strengthen organized medicine in our county, it might forego its meeting at this time.

We are proud of the progress of our state organization but its strength depends on alert well functioning county medical associations.

I am reminded of the lamentation to which James Hilton gave vent in his novel "Random Harvest," explaining why the League of Nations had come upon evil days. He said, "it's sickening now of that deadliest of modern diseases—popular approval without private faith; it will die because it's worth our passion and we deluge it with votes of confidence and acts of indifference."

I bespeak your passionate devotion to medicine in Connecticut.

James R. Miller, M.D.

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## MEDICINE AND NATIONAL SECURITY

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**A**N EFFECTIVE medical service available to all portions of the population is a primary essential for the national security. The rapid mobilization of medical personnel at the outbreak of the last war withdrew large numbers of doctors from civilian practice and placed them at the command of military leaders. Over 60,000 medical doctors joined the military services for approximately 15,000,000 military personnel. This left approximately 100,000 doctors available for the remaining 125,000,000 of the nation's population. An over supply of doctors resulted within the military ranks. While here and there shortages may have temporarily developed, at no long period of time was there any lack of doctors; in numerous theatres and installations there was an over abundance.

In the interest of a higher degree of efficiency of medical service for the armed forces and the population of the nation a study of the medical experiences of doctors should prove of value. This survey should include a consideration of medical needs, assignments to duty, utilization, rotation of service, promotion, etc. Such an examination is of great importance today when one considers the present instability of international relationships. The diplomatic branches of the nation, the military services, social organizations, educational agencies, are reviewing their experiences for the purpose of bring-

ing about a more efficient plan of action in the event of future need. A review of the medical experience should prove enlightening. . . .

In time of great national peril the temper of the population is quickened in the direction of the support of military leaders. In a determined and energetic effort to overcome the enemy, the general staff demanded a supply of medical personnel in total disregard of essential civilian needs. It has become apparent that the needs of the civilian population in time of war must be forcefully presented to military leaders. The practice of non medical departments being held responsible for the selection and assignment of medical personnel has resulted in great waste of talent and produced an over supply in many categories with practically a universal shortage of doctors for non military needs. . . .

### NEED FOR COORDINATED MEDICAL PROGRAM

The medical profession needs to have a program that will adequately serve all portions of the population—civilian as well as military. In the event of future catastrophic involvement, the medical problems inherent in such action assume an importance almost co-equal to that of the military aspects. The isolation of military planning at the expense of civilian requirements is not in accord with protection for all groups of the population. Bitter experiences from the last war indicate a definite need for frequent consultations between the military and medical authorities for the establishment of an overall plan of medical service.

The present relatively inferior position of the

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*Printed in part from an address given at the Forty-Third Annual Congress on Medical Education and Licensure, sponsored by the Council on Medical Education and Hospitals, American Medical Association and the Federation of State Medical Boards, Chicago, February 10, 1947*



Surgeon General of the Army in reference to the general staff is bound to work hardships on the medical service of the Army. It is difficult to conceive that a line officer would have the necessary knowledge and experience that would fit him to guide the destinies of the medical corps. Line officers are responsible for military decisions, the Surgeon General for medical affairs. The vitality of the military personnel, their physical training, prophylactic treatment and care when sick or injured, requires the greatest skill on the part of men trained in the field of medicine.

The appointment of outstanding authorities in the various special fields of medicine to act as consultants to the Surgeon General is commendable. The real value of such policy depends on the responsiveness of military authorities to the suggestions of the consultants. Experience in the last war indicates that much is still to be accomplished in this direction.

#### THE NEED FOR A UNIFIED MEDICAL CORPS

The lack of any coordination on the part of the Army and Navy Medical Corps during the last war resulted in numerous unnecessary duplications of effort, and occasionally expensive duplication of construction and equipment. There is definite need for a unified medical corps. This organization should be under the direction of a council that would include top ranking representatives of the various armed services and civilian authorities representing the fields of medical education, practice, administration, and research. A medical council of such stature would be held responsible for organizing a program of medical service which would take cognizance of the over-all needs of the nation at peace and at war. This would immediately eliminate the competitive bidding for specialists and non specialists alike. It would remove the possibility of wasteful duplication of buildings. Such a council would offer the general staff information of the utmost value in estimating criteria for physical fitness and setting up a physical training program as the needs would arise. Such a council would be able to advise the President, his Cabinet, and Congress concerning the details of a medical program that would offer adequate scope to young men in the field of medicine. Opportunities for advanced training in the basic sciences and in the specialties would be created that should prove attractive to young men interested in a military medical career.

#### MILITARY MEDICINE AS A CAREER

As long as the nation finds it necessary to maintain a military force for its protection there will be need for a medical department. As officers are trained for the line so should promising young doctors be trained in the basic medical sciences and special fields of military medicine. Professional opportunities appear infinite. The ordered life is attractive. Associations are pleasant. Financial recognition, while modest, is not probably a major deterrent in keeping young men out of the medical corps. Relatively few of the nation's promising young doctors today look upon a career with the armed forces as sufficiently attractive to sign up. Indeed at present documentary evidence suggests that many young doctors are being held against their desires in positions that offer no opportunities for medical experience or growth. Such a condition should not be permitted to continue, primarily because it will further react against a possibility of winning the support of medical graduates in the direction of a medical military career in the future.

One cannot over-emphasize the need for a highly qualified medical department. When the authorities, including members of the general staff and the Bureau of Personnel, consider the medical needs of the services in conference with authorities of the medical profession, a major advance will have been attained. The present unrest and widespread dissatisfaction with many minor points of life as a doctor with the armed forces should stimulate authorities to analyze the irritants and the obstacles for winning the confidence of America's young doctors so that errors can be corrected and a loyal medical corps of highest calibre can be created.

A valuable suggestion has been made that each year a certain number of scholarships to medical schools should be offered by the government to prospective medical students on the same basis as applicants are now selected for training at West Point and Annapolis. Following their training these young doctors would agree to spend some time on active duty and then, if mutually desirable, to go on inactive status as a member of the Reserve Corps but continue their affiliation with the Medical Corps. Selection of students on the basis of aptitude for a medical career would uncover a number of highly desirable applicants who otherwise might be eliminated from a life of service in medicine because of the exorbitant financial requirements for the study

of medicine as it now exists. Such a program as pointed out by Dr. Harold Diehl of Minnesota would furnish a group of superior young doctors each year for replacement needs in the medical corps. They would serve as key men in student bodies to interpret the medical career with the military services in the light of excellent opportunities with the armed forces. The quality of medical talent thus selected would furnish candidates for research programs in military medical fields that would extend scientific knowledge in medical fields peculiar to military action.

In time of war the nation's population must accept a military dictatorship for its own survival. During peace time however there should be adequate opportunity for conference with the military high command to assure the highest quality of medical service to the armed forces at all times. The absence of a well thought out program preceding our entrance into the last war created the situation of a military dictatorship which mobilized the medical reserves of the nation with insufficient understanding of the capabilities of modern medicine. Unnecessary wasteage resulted from lack of planning. It is high time that a modern program be drawn up in the best interest of medical service for all groups.

#### MEDICAL ADMINISTRATION

Hospital administration is now a recognized special field in medicine. Medical men with a flare for this kind of executive work, and who possess administrative ability, should find a most attractive career in this rapidly expanding field in governmental service.

The practice of the Navy in using top ranking officers in administrative capacity does not by any means insure a qualified man in an administrative position. Innumerable instances are known where clinicians of outstanding ability have been removed from care of patients to place them in administrative positions for which they were neither by interest or ability well equipped.

The development of a medical Administrative Corps under a unified military service should eliminate the assignment of clinicians for administrative duties. These two branches of medical service are complementary.

#### SUPPLY OF DOCTORS

A continuing supply of doctors is of the first importance in time of war. Any threat to the con-

tinuance of the supply is a definite threat to medical care for the entire nation. Towards the latter part of the last war an acutely serious shortage of qualified students for medical training developed. Had the war continued this would have brought about a desperate emergency. It resulted from lack of appreciation by Selective Service of the need for doctors. Such a situation should not be permitted to arise in the future. The solution is simple. The selection of qualified students for medical training should be made at periodic intervals by a combined Board representing authorities of medical schools whose business it is to estimate the capabilities of aspiring students, in collaboration with representatives of military service who are cognizant of the military needs.

While short cuts in pre-medical curriculum may not result in serious deficiencies, the accelerated program for the medical course is open to question. The trainee can absorb just so much. To force data upon an overworked student obviously results in inadequate training. A certain amount of maturation time is required for students to grasp the significance of the instruction they are being given. The fatigue element for both teacher and student results in increasing strain under the accelerated program. Even on the four year basis the graduate is scarcely equipped to give a creditable performance.

Complete subsidization of medical students is neither necessary nor desirable. Many students are quite capable of meeting their responsibilities. For others financial aid in the form of loans either by the schools or other sources will not create a financial obligation to the government that has in past reacted unfavorably for the trainees.

More attention to the military aspects of medicine should be a necessary part of the training of all medical students in peace time. Then, when, and if, an emergency should arise they will have had some introduction to the special aspects of coming experiences. This problem increases in importance when one endeavors to estimate the medical casualties that would result from the widespread use of atomic bombs, biological and chemical agents, and psychological propaganda in the future. The problems of clothing, housing and mess are relatively minor and can be worked out as the occasion arises.

Our military authorities might with profit examine the practice of Canadian and English military groups in fitting the medical program to the over-all needs of the nation.



# QUALIFICATIONS OF MEDICAL OFFICERS

A bill recently introduced into the United States Senate known as the "Fulbright-Taft bill" provides for a Department of Health, Education, and Security. Under this bill the head of such a Department would have Cabinet status. If, as General George Marshall stated recently "Health is the great wealth of the nation . . ." then it would be reasonable to have an authority on health in the President's Cabinet. American medicine has long been interested in endeavors to obtain representation at the Cabinet level.

The medical problems of national security should be studied by the nation's leading authorities in the various fields of medicine and their application to the nation's health. Appropriate recommendations of those qualified to estimate the nation's needs should have adequate recognition and consideration at the highest civilian levels. Yet in a recent proposed reorganization of the War Department the Medical Department is placed in charge of a technical advisor to the director of the general staff. Gross inefficiency will arise from such a plan if enacted. Medical science, and the benefits to be derived therefrom, is so complex that it would be impossible for non medically trained officers to estimate the potentialities involved.

In the interests of having a top flight unified medical service for all branches of the armed forces, bottlenecks and restrictive regulations need be eliminated. American medicine has great confidence in the competence of the group of distinguished doctors appointed to the medical advisory committee of the Secretary of War. The profession's sole concern is that the recommendations of this eminently qualified group be translated into effective results. With unification of the services such a group should be concerned with an over-all medical program.

Since the day is passed when any medical officer is qualified to perform any medical duty, the acceptance of this fact will prove a definite step forward. There is need for the creation of pools of medical officers in the various categories. These pools should be set up on the basis of medical specialties rather than military rank. As the need for specialists arises the particular qualifications of the various men available within the pool should be examined and the man to fit the job should be appointed. This is in sharp contrast to the practice of the recent war in which too many doctors were assigned according

to rank with relatively little attention paid to their medical qualifications.

## THE CHANGING CHARACTER OF WARFARE

Towards the close of the last war two relatively small atom bombs were detonated. The results of these demonstrations produced an effect on international relationships that was far reaching. Reports are current that really large atom bombs can be produced that will wipe out entire metropolitan communities.

Biological warfare has been widely commented on in the national periodicals. *Life* magazine, November 18, 1946 states that "Biological warfare using various products of disease may be as devastating as the use of atomic energy and, indeed, as troublesome to combat." From other sources, chemical agents more deadly than the cyanides are available to equal the destructiveness of atomic energy and biological products. Psychological and propaganda methods which create unrest and division throughout the nation's population offer another major destructive method.

In the *Chicago Sun* of December 9, 1946 there is a statement by Griffing Bancroft that atomic power makes battleships and airplane carriers obsolete. Naval authorities are of the opinion that mechanization of aviation makes the airplane pilot obsolete. In the opinion of naval military leaders the use of mighty underwater craft, which are capable of cruising for months under the surface, is a necessity. These craft would come to the surface for the purpose of loosing rockets or depositing troops on enemy shores. In the opinion of many competent authorities the large battleship navy is a thing of the past.

Army military authorities are considering methods that will be utilized in the next "super blitz" emergency.

In any future war the metropolitan communities wherein civilian population are concentrated will be the major objectives of hostile powers.

## PRACTICAL PLANS FOR NATIONAL DEFENSE

In a recent editorial in the *New York Times*, December 1, 1946, New York State was described as the first to set up a community program which might be activated in the event of an assault on our nation. General Hugh Drum publicly stated that "Organization by New York State of the first mili-

tary body in history to defend the home front against an atom bomb attack is not designed to make anybody's flesh creep. No assault by fission missiles is anticipated in the near future. But if it ever comes to such a populous community, common sense tells us it would be catastrophic. The State War Disaster Military Corps is therefore a sober provision of forehandedness which other communities would do well to consider and follow. The S.W.D.M.C. is only part of a general plan for the expansion of the National Guard to enlarge our Federal defense forces. In the beginning it will be strictly a State responsibility. But in view of its purpose it is the most striking feature of the larger plan. Essentially it is an effort to provide a trained nucleus to step in and restore discipline and order in a civilian population demoralized by sudden disaster. Obviously no civilian defense corps resembling those we had in the last war could hope to handle such widespread disorganization of normal life as a single atom bomb would cause. So far the United States has expressed little interest in such a disaster force. New York State is pioneering in the field. But it is already high time to take practical thought of the terrible new weapons science has developed and to consider their use by other hands than ours. The great cities of this State will remain inviting targets for swift attack. The S.W.D.M.C. should drive into the public consciousness the inescapable fact that humanity, for good or ill, has passed into the atomic age. While mankind is still struggling to work out some means of curbing its destructiveness we must prepare to meet it."

National security requires the participation of the adult and youthful population of the nation for its common defense. In the face of weapons capable of mass community destruction the basis of neutralizing enemy assault must be by relatively small technical groups of experts capable of highly mobile and flexible methods of neutralization and retaliation.

It is difficult to visualize the use of large troop formations as a wartime instrument in the atomic era. Had an atom bomb been dropped on Iwo Jima the priceless lives of 5,000 American heroes would have been saved. The day of individual combat and beach assaults has passed. Military troops in the future will find their probable utilization as occupation forces after the storm. With this evolutionary development in the science of international conflict it is difficult to evaluate the justification for a national program of compulsory military training.

There can be no doubt that military training of the nation's youth in the forms of discipline, physical training, and essentials of team work are beneficial. A program for training in these essentials might readily be incorporated in the secondary schools and colleges of the nation without disrupting other essentials in the national educational program.

#### TROOP STRENGTH VS. MEDICAL NEEDS

Attempts to supply medical personnel to troops on the basis of 6.5 per thousand proved wholly unsatisfactory during the last war. The estimate for the medical needs of armies in battle and in the rear areas should be entirely on the basis of calculated casualties. Military and medical authorities rapidly became competent in predicting the number of casualties that would result previous to engagements in the last war. It would have been relatively easy to have medical units available in rear areas and taken by air to areas where needed. The maintenance of inflexible tables of organization was a prominent feature in wastage of doctor supply. Excessive reverence for rigid tables of organization tied up many valuable medical officers who, when not needed for active medical duties with the armed services, might well have been utilized in relieving the drastic shortages in many civilian communities. Fewer civilian doctors would have had coronary arteries blocked had such a program been set up.

In the light of the fantastic developments in atomic and biological warfare, the use of highly toxic chemical agents, and the elaborately designed measures of psychological assault, the type of casualties to be expected can be readily estimated. There will be relatively less need for field medical units, beach landing parties, and mass troop movements.

There will be relatively greater need for adequate medical personnel and equipment assigned to civilian population centers. In the light of modern weapons which are capable of destroying large concentrations of troops and civilians alike, it can safely be predicted that the day of the rifle, machine gun, and indeed surface battleships is drawing to a close. Military masterminds behind the scenes realize this. It is high time the nation as a whole faces such a possibility. It is too much to expect that the world has seen its last war.

It can safely be estimated that the next war will not last long, that there will be a tremendous number of casualties, and probably civilian casualties will be greater in number than troop casualties. Pro-



vision for medical care should be made accordingly.

#### THE MEDICAL RESERVE CORPS

Previous to Pearl Harbor the Medical Corps of the Army and Navy were operating with a skeleton crew. The rapid expansion at the beginning of hostilities mobilized the medical reserves so that probably over ninety per cent of the actual work was performed by reserve officers. While some representation for reserve medical officers existed within the offices of the Surgeons General, many problems arose which indicated the need for a more intimate understanding of the problems of the reserves by those who determined the policies of the corps.

Coercion, veiled threats of unsatisfactory assignments, unfulfilled verbal promises, and other unwholesome attempts for undue influencing of younger medical officers against their better judgment should have no place in the activities of the medical departments of the armed forces.

National security requires that every doctor should be available for national service in time of emergency. Reserve medical units at the various levels in administrative, clinical, and research fields should be organized during peace time and should be kept continually in touch with the activities of the service medical corps. Insofar as possible the division between the career officers and reserves should be minimized. This is especially true in the field of medical education and research.

#### PROMOTION IN THE MEDICAL CORPS

The capacity, training, and experience of a doctor should represent the criteria for determination of his military rank. As an officer gains in knowledge and value professionally, these facts should serve as the basis for advancement. Medical proficiency and rank should go hand in hand. Certification in the various specialties was recognized during the last war. Unfortunately well qualified clinicians by

virtue of age and years of experience were often removed from clinical duties and given administrative assignments purely on the basis of military rank. This problem should offer little difficulty when properly recognized by the policy making Board responsible for the creation of an efficient and modern Medical Corps.

Doctors in special fields when maintained in their chosen work, should have expanding opportunities for extending the frontiers of medical science. In this way the medical service of the armed forces would soon have research programs co-equal in excellence to that of civilian organizations. This principle should be encouraged by adequate recognition when rank is assigned.

#### CONCLUSION

In conclusion the principal medical needs for national security may be summarized as follows:

1. An over-all medical program for all groups of the population.
2. A Secretary of Health in the President's Cabinet.
3. A Medical Council with representatives from the medical schools, professional organizations and military officials.
4. Guarantee of a continuing supply of medical officers.
5. Appointment of doctors on basis of ability rather than military rank.
6. The creation of opportunities in the Medical Corps for graduate training and research.
7. Organization of an energetic Medical Reserve Corps.

If these principles are utilized in the formulation of the national policy for health and medical care the benefits of modern medical science will be extended to the entire population of our great land.

## PULMONARY SARCOIDOSIS

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### DEFINITION

The title, "A Chronic Pulmonary Disease of Unknown Origin," aptly describes the disease. If we were to give it a pathological name, it could be called chronic pulmonary granulomatosis, pulmonary sarcoidosis, or miliary sarcoidosis of the lung. It has been spoken of by others as, "beryllium sarcoid;" this name is a little premature because it has not yet been proven that beryllium is the cause. It has also been called, "delayed chemical pneumonitis," again a very doubtful nomenclature because it is not as yet proven whether it is infectious or chemical.

### ONSET AND SYMPTOMS

In the last four years as an industrial physician, I have met with thirty-five cases of this disease. The disease has quite characteristic symptoms, signs, and clinical course. It has an insidious onset. The patients usually will have been sick for two or three months before they realize there is anything seriously wrong. They think they have a cold and a tired feeling, but expect to get well in a few days. Eventually they realize that this is something serious and consult a doctor.

For example, one soldier in the Army developed the disease. He was admitted to one of the Army hospitals, remaining a patient there from October until March under treatment for psychoneurosis. Then a routine chest x-ray revealed the diagnosis. It was realized only then that his symptoms fitted in with the disease that I am going to describe.

The onset of the disease was, in many of the cases, associated with certain events or illnesses. Seven of the thirty-five cases were pregnant within a year of, or at the time of the onset of the disease. One individual had paratyphoid fever; with the paratyphoid fever he got a pulmonary condition which turned

out to be this disease. The onset in another case followed an attack of herpes zoster. In two of the patients rheumatoid arthritis preceded the lung condition, and in another, a cholecystitis. In four of the cases the onset occurred while the individuals were in the Armed Services and may have been related to the rather strenuous training regime.

The first and most noticeable symptom is shortness of breath. The patients find it difficult to go upstairs. They are short of breath. With the shortness of breath there may or may not be cyanosis and clubbing of the fingers and of the toes.

The patients have a cough which is non productive. It has a nervous element. With stress or emotional disturbance, the cough may start and become paroxysmal; the person may perspire profusely in such attacks. They just can't seem to stop the cough. In the treatment of the cough, sedatives may give relief; sucking a lozenge or piece of candy may abort the paroxysm. The cough tends to be worse shortly after the patient gets up in the morning, as is so common with tuberculosis. A change of posture or sudden physical activity may start the coughing. But as the cough is non productive, little or no sputum is raised.

The patients may have a pain in the chest, which usually can be recognized as muscular, although in some cases, slight pleurisy is recognized by x-ray.

Practically all the patients have shown considerable loss of weight. A few have lost as much as thirty pounds in the course of three or four months. With the loss of weight, there has been loss of appetite. In the occasional cases that the loss of weight was not very marked, the appetite continued to be good. The patients complain of a tired feeling and the fatigue that goes with loss of appetite and weight.

Skin lesions occurring on the fingers, on the front of the thighs, and shins were noted in five of the cases. These skin lesions are similar to papulonecrotic tuberculids, being shotty and hard, persist

*Presented at a symposium on "A Chronic Pulmonary Disease of Unknown Origin" at a meeting of the Industrial Health Committee of the Connecticut State Medical Society, November 20, 1946, at Waterbury*



ing for some time, and eventually desquamating. By microscopic examination, these lesions removed by biopsy have been diagnosed as typical sarcoid.

At least three of the patients were treated for hyperthyroidism, because they showed some of the characteristic nervous symptoms; but when a basal metabolism test was done, it was found to be normal. One of these patients had a goiter; she was admitted to a hospital for operation. When an x-ray film of the chest was taken, the diagnosis was changed.

Many of the patients have had difficulty in adjusting to their physical handicap. They must learn to live with the disease. If their emotional system won't let them calm down and live with the disease, phobias, uneasiness, and nervousness stand out. However, the person who has a rather placid disposition will usually adjust quite well.

The disease has been observed both in men and in women. The men have borne their disease better than the women. Most of the men have been able to get back to work, whereas, the women were more likely to be totally incapacitated. The ratio of male to female patients has been about the same as of male to female employees in the plants affected.

A curve plotting the ages of the patients was found to parallel the curve for the ages of all the plant employees. The ages of the patients at the onset of the disease ranged from 20 to 51 years.

#### PATHOLOGY

Pathologically, the disease is characterized by granulomata. Epithelioid cells collect and form giant cells; miliary nodules gradually form in the lungs. In some cases, there are lesions of the skin; post-mortem, occasional granulomatous lesions of the liver and spleen have been found. But it is essentially a disease of the lungs. The hilar lymph glands are almost always affected. The nodules may be as large in size as a granule of Minute Tapioca.

At autopsy, section of the lungs may reveal that some of these nodules have undergone degeneration. They may either have become hyalinized or there may be some necrosis. But the lesion, which looks like a miliary tubercle, does not progress to caseation as does the tubercle.

The pathological and x-ray pictures are suggestive of silicosis; but, they are different from silicosis. In silicosis the nodules all tend to congregate gradually toward the hilar glands. In these cases the nodules stay out pretty diffusely throughout the whole lung areas, as shown by x-ray films of the chest. The

amount of silica found present in the lungs, post-mortem, was well within normal limits and did not fall within the range found in cases of silicosis.

#### CLINICAL PATHOLOGY

The clinical pathology in these cases has revealed a normal white and red blood count. In a few cases the red count was elevated, a reaction to cyanosis and difficulty for the oxygen to pass from the lungs into the bloodstream. This hemoglobin in some cases similarly was elevated; but usually it was found normal. The albumin-globulin ratio has been found normal in these cases, although in certain granulomas a high globulinemia has been found.

#### BACTERIOLOGY

The bacteriological study on section of a number of lungs has revealed acid fast bacteria which appear to belong to the group of diphtheroid bacilli. This organism was found in nearly every one of the autopsied cases. It has also been recovered from the bloodstream of one patient and from several specimens of sputum. In all, I estimate there have been about eight or ten cases in which this organism has been found by bacteriological stains in tissue or sputum; and in a few instances, it has been possible to obtain a living culture.

This organism takes the acid fast stain, but, the acid fast characteristic seems to disappear fairly easily. Thus, when the organism was added to media containing quinine, it lost its acid fast characteristics. It is likely that other changes in media and environment will cause the same change.

This organism offered promise of explaining the cause of the disease. When the tubercle bacillus enters the lungs, some chemical component, presumably in its acid fast characteristic, acts as a chemotaxic agent to draw these epithelioid cells together around the tubercle bacillus to form a tubercle. One would presume that the chemistry of another acid fast organism, an acid fast diphtheroid, might have similar chemicals which would attract these organisms.

This possible cause of the trouble was very intriguing. The organism was not found in tuberculous patients, nor in normal individuals. And yet it was found in several of these thirty-five cases that I have mentioned. But before one accepts this micro-organism as being the cause of the disease, other proofs are necessary. The organism could not be proven pathogenic; the pathology was not produced when it was injected into animals. Diphtheroid or-

ganisms are found normally in the human body. Bacteriologists tend to regard them lightly as a cause of disease, and ordinarily are not greatly intrigued by the possibility of their causing trouble. However, that lead needs further study, and it may be that these acid fast organisms are a factor, perhaps together with some other factor, which may cause this unusual disease.

#### PHYSICAL EXAMINATION

Physical examinations, beyond revealing a thin, anxious, and possibly cyanotic individual, have been surprisingly negative. No sarcoid lesions have been observed in the eyes. Lymph nodes are not enlarged. The mouth and throat are normal. The liver and spleen are usually not palpable nor enlarged. The skin may show miliary sarcoid nodules in the early stages of the disease. The lungs, since the pathology is bilateral, reveal nothing by percussion. In many of the acute cases crepitant rales are heard, usually at the heart borders and the lung bases.

#### CHEST X-RAY

The shadows seen in the lung areas on an x-ray film present a very characteristic picture which is readily recognized by one who has seen several cases. There is a diffuse granularity and nodulation throughout the entire lung fields equal on the two sides and in all five pulmonary lobes. The appearance of the lesions at first suggests miliary tuberculosis and silicosis. The extent of the lesion as related to the symptoms and the location of the lesion tend to differentiate sarcoidosis. Granularity tends to be the earlier manifestation with a tendency after a few weeks for nodules to become more marked. However, this is not always the case. The degree of involvement by x-ray usually, but not always, parallels the severity of symptoms and signs. The diffuse spread of the nodules throughout the chest is quite suggestive that the cause is through the bloodstream and not by inhalation. The exposure time of a film may confuse one as to the severity and extent of the lesion when one compares two films of the same person taken at different times or films of different patients.

The x-ray pictures have revealed that from the onset about two months elapse before the maximum amount of shadow is present. Many of the patients have had x-rays taken before the onset of the symptoms. These were normal. One patient had a normal x-ray even as short a time as two weeks before the onset of the disease. After the maximum involve-

ment has been reached at the end of two months, there is rarely any change. Three of the cases, however, have shown complete dissolution of the pathology. A few others have shown diminution in the amount of shadow; but the shadows in most of the patients remain unchanged. In some patients, there does seem to be a tendency for less granularity and more nodulation but with approximately the same extent of involvement after the second month.

#### BASIS OF SYMPTOMS

The disease is definitely in the interstitial tissue of the lung and not in the bronchi or alveoli. That explains why the patients seldom, if ever, have any sputum except when they have an acute superimposed respiratory infection. The main difficulty encountered by the patients is the inability to get satisfactory transfer of oxygen from the alveoli to the lung capillaries. The granulomatous tissue in the lung will diminish the vital capacity; thus, some of the patients have as low a vital capacity as 1 liter. Some other patients have had a nearly normal vital capacity. When the patient gets a cold, it is observed that the vital capacity diminishes. As the disease progresses there has been observed little or no change in the vital capacity. In general, one can say that there is a low respiratory reserve which when respiratory infections occur, may lead to serious respiratory distress.

#### CLINICAL COURSE AND PROGNOSIS

Even during the acute or active stage of the disease, that is during the first two months after the onset and when the granulomata are forming, there is essentially no fever. The loss of appetite and loss of weight usually continue during the active phase of the disease and perhaps for a month or two more. This weight loss may be as great as thirty or forty pounds. After a few months the fatigue becomes less marked. The cough is controlled and the shortness of breath becomes less noticeable when the patient has learned not to overdo and becomes emotionally stable. The individual, who has difficulty learning to adjust to the disease, may continue to have symptoms as cough and anxiety for considerable length of time. In some instances the cough will seem to persist, a conditioned reflex to a difficult environment having been established. Individuals may go for months without any serious difficulty providing they keep within their physical capacity. In this regard there is a similarity to some cardiac disorders.

There are varying degrees of incapacity from



what may be called essentially asymptomatic disease to a total incapacity requiring constant rest in bed. Of the thirty-five cases there have been six deaths. One death was due to respiratory spasm, two to cardiac decompensation, and three to acute respiratory infections. Heart failure has been more a symptom of the older than of the younger patients. Only one patient of the twenty-nine now living is a bed patient.

#### TREATMENT

Various methods of treatment have been tried without any consistent benefit. However, since most of the cases had not been discovered until the acute phase of the disease was over, a real test of antibiotics has been difficult. Sulfa drugs, penicillin, and streptomycin have been tried. The use of streptomycin should be tested further, especially since it is believed to be of some value in tuberculosis. Iodides have been given in the hopes of causing disintegration of the granulomatous nodules such as occurs in tertiary syphilis, gummata, and in tuberculosis. Quinine and neoarsphenamine have been used with possible benefits. It has been generally felt that absolute bed rest was not the best therapy except in acute episodes as when the patient gets a cold. Experience with cases of silicosis has indicated that patients do better when they are allowed up and working within their capacity. The same procedure has been our recommendation in cases of sarcoid.

#### OCCUPATIONAL HISTORY

Thirty of the thirty-five cases were employees who had worked in 1940 and 1941 on one of four floors of a given building of an industrial plant. Three of the four floors were assigned to the manufacture of fluorescent lamps.

All but two of the thirty-five patients had been engaged in fluorescent lamp manufacture. Of those two patients, one worked in Tungsten Wire Department and the other in Experimental Lamp Department where sterile and strobatron lamps were made. Twenty of the employees, later patients, were transferred to another plant in a different municipality, four miles distant, where the whole fluorescent lamp manufacture was moved on December 7, 1941. Three cases have developed in individuals who worked in this second plant and not in the first plant. No employee hired since September 1942 has developed the disease. Two cases have developed in a plant of the same company manufacturing fluorescent powders in another state.

#### FLUORESCENT LAMPS

A fluorescent lamp is a mercury vapor lamp. The mercury vapor produces light rays, most of which are in the ultraviolet range. The ultraviolet light, on striking a coating of fluorescent powder on the inside of the lamps, is changed from invisible light to visible light. Fluorescence involves a change in the wave length of the light. There are certain substances which will cause this change; they are called phosphors. Variation in color is obtained by use of different phosphors or combinations of phosphors. No ultraviolet light comes out into the room from a fluorescent light for two reasons: (1) the fluorescent powder changes its wave length; and (2) even if there was no coating there, glass of the tube would absorb the light.

#### EPIDEMIOLOGY

About one-third of the patients worked in the Stem and Mount Departments. This work involves the making of the electrodes, which later, in another department, are fused into the ends of the tube coated with phosphors. The employees in this department did not handle phosphors.

About one-sixth of the patients worked on the manufacture of the phosphors, on the making of the phosphor paint, on the coating of the tube, or the baking of the tube to remove solvents, lacquer, etc. Workers in these departments handled phosphors to a greater or less extent.

About one half of the patients were in the Finishing Department, where the electrodes were sealed to the tube, the tube exhausted of air, argon and mercury added, base sockets attached, the lamps tested and packed. These employees may get some powder on their hands from the outside of the tube.

The individuals were scattered over the plant, one on the first floor, some on the second floor, some on the third floor, and some on the fourth floor, which wasn't given over to fluorescent lighting at all. The length of time that they worked there was no factor. One girl that got the disease had worked only six weeks, while another had worked on fluorescent lamps as long as four years.

Although there were thirty-five cases, only fifteen were working for the company at the time they got sick. And interestingly enough, only three of the fifteen were working on fluorescent lamps at the time they got sick—two being in the Stem Department.

The epidemic shows certain distinctive features.

One is that all these individuals were working on fluorescent lamp manufacture between 1940 and 1942, thirty of them in one building. However, with some of the patients the work period was in 1940, with some in 1941, with some in 1942, and with others in two or three of these years.

Assuming that this common work represents an exposure to the disease, it is quite apparent that a prolonged period of waiting—an incubation period—exists between the exposure and the onset of symptoms. It is somewhat difficult to set an exact incubation period on this basis inasmuch as the exact time of exposure cannot be narrowed down in many cases to a time limit of several years. However, the following chart will give some estimate as to the incubation period. The first line marked "minimum" represents the time between the date the person last worked in the manufacture of fluorescent lamps and the onset of symptoms. The second line represents the midpoint of the person's employment on fluorescent lamp manufacture and the onset of the disease. The third line represents the midpoint of the employment prior to September 1942 and the onset of symptoms. Thus, it would appear that the incubation period is probably very seldom less than one year, that the average time has been approximately three years, and that an incubation period in excess of four years is not uncommon.

TABLE I

Incubation Period	0-1 yr.	1-2 yrs.	2-3 yrs.	3-4 yrs.	4-5 yrs.	over 5 yrs.
Minimum	8	8	6	4	2	0
Average (a)	1	7	7	7	6	0
Average (b)	1	5	7	6	5	3

An example of a long incubation period is that of a man who worked on fluorescent lamp manufacture for six months prior to May 1941, when he left the company. He reported sick in June 1946 with symptoms which may have been present for four or five months.

The time of the onset of the disease is not seasonal. Of the thirty-five cases, there were no more than five in any one month of the year. The onset was in the winter in six cases, in the spring in ten cases, in the summer in nine cases, and in the fall in seven cases. It is also well established that so far as x-ray, symptoms, and physical findings were concerned, these people were perfectly well before the date of onset. The acute disease seemed to run a course of two months, and then one dealt with residual damage.

It is difficult to spot a causative factor that may have existed four to six years previously. Although much of the same manufacturing processes were used then as now, the same cause does not seem to exist at the present time. Changes in conditions depend upon the memory of a few of the manufacturing personnel, engineers, and safety men who supervised the work at that time. Details after so long a time are easily forgotten.

Table II gives the dates of the onset of the disease and symptoms of the thirty-five patients, and whether they were working for the company at that time.

TABLE II  
ONSET OF SYMPTOMS  
(Common Employment January 1940 to September 1942)

YEAR OF ONSET	TOTAL PATIENTS	PATIENTS WORKING FOR THE COMPANY AT ONSET OF SYMPTOMS
1941	2	2
1942	2	2
1943	10	2
1944	4	2
1945	10	6
1946	7	1
	—	—
	35	15

At the time of the onset on the disease, twelve were working for the company, but not on fluorescent lamps; three were working for the company on fluorescent lamps; four were in the armed services; eight were at home, and six were working for other companies not engaged in fluorescent lamp manufacture.

ETIOLOGY

The clinical picture of this disease has been presented. The question now arises as to the etiology or cause and why there have been so many of these cases in one location and one industry. The disease does not fit in exactly with common conceptions of Boeck's Sarcoid in that most of the latter cases were supposed to get well. But pathologically, the lesion is sarcoid, a granuloma, and quite a rare condition, although roentgenologists are beginning to realize that it is more common than had been supposed.

Of the possible etiological causes, one may list:

1. Infection due to bacteria, viruses, fungi, rickettsia, or protozoa.
2. Reaction to necrotizing tissue.
3. Allergy.
4. Chemical agents.



## INFECTION

Granulomata are found in diseases caused by the various infectious agents mentioned above. The tubercle bacilli are the best known causes of granulomata. Its chemistry serves as a chemotaxic agent to attract the epithelioid cells to cause the formation of tubercles. About half of the articles on sarcoid in the literature mention tubercle bacilli as the cause of sarcoid. Sarcoid is described as, "miliary tuberculosis which gets well," as, "tuberculosis without allergic reaction," as due to, "avirulent tubercle bacilli," etc. None of the cases listed here had clinical tuberculosis and most of those tested had negative tuberculin tests. There was no epidemic of tuberculosis in the plant, nor more than .2 per cent active tuberculosis found among employees on group x-ray tests. Active tuberculous infection may have a varying and prolonged incubation period. Possibility of analogous acid fast organisms arose; acid fast diphtheroids were found as mentioned earlier. Sputum studies and examination of necropsy material continues as it becomes available.

Leprosy is characterized by granulomata and a prolonged incubation period. Sarcoid is not due to the leprosy bacilli, but again the possibility of an analogous organism must be considered.

Viruses have been searched for without success, chicken embryos having been used. It will be recalled that the incubation period is long in certain virus diseases, as hydrophobia.

Fungi have been searched for and in our cases without success.

Protozoa as found in various types of Leishmaniasis have been suspected as pulmonary lesions have been described in these conditions. No Donovan bodies have been detected in our cases.

Syphilis in the tertiary stage is characterized by gummatous granulomata. While negative serology in the cases has been the rule, analogous infections must be considered possibilities.

The plant is located along a river which flows through one of the largest tannery districts in the United States. Probably more hides are tanned here than any similar area in this country. These hides may come from South America, Australia, Africa, in fact, from all over the world. One wonders if perhaps some infectious agents have been brought in with the hides and tend to flow down the river. This river going by the plant has been very polluted. It has foul odors and fish cannot live in it because of

the bacterial action present. Also sub-surface drainage from factories from a hill near the plant tends to flow through the plant area, and at times of high tide and severe rain, the cellar of the plant has been flooded with water having the odor of tanneries.

The ventilation of the plant has been by means of large fans which carry off the air. This is replaced to some extent by air which has been washed by water obtained from wells sunk in the property. Occasionally this water had a tannery odor. Contagia from these sources were considered.

In summing up, there is considerable evidence that points toward the fact that we are dealing with an infection: first, the nature of the lesion, which is similar to tuberculosis; then, the timing, wherein the disease appears three or four years after the last common exposure; the fact that we were able to get a certain common bacterium in several cases, although its pathogenicity hasn't been proven as yet. The possibility of a carrier arises.

About a week ago we learned of the first instance where there were two cases in one family. One of the patients, an employee of the company on fluorescent lamp manufacture from May 1941 to July 1942, was taken sick in December 1943, just about the time she became pregnant. She had had a normal chest x-ray in July 1943. She was quite sick with dyspnea and shortness of breath. The uterus pressing on the diaphragm diminished the ability to breathe satisfactorily and the dyspnea became so intense that in the eighth month of the pregnancy, an emergency cesarian operation was done. The baby died one hour later; the mother continued to be very sick and to cough considerably. After one month the patient went home. During a ten-month illness her mother acted as nurse much of the time. The patient died in October 1944. In October 1946 her mother came down with the same disease. The mother never worked in the plant. This instance points rather distinctly toward infectious etiology as the mother's exposure to fluorescent powders must have been quite small, and the incubation period between the time the mother acted as nurse and the time she came down with the disease is comparable to the period between the times the daughter worked at the plant and she came down with the disease.

There have been only two other cases in the city and surrounding towns that have come to our attention. The mother of an employee who worked in the plant in 1941 came down with the disease and died. She had never worked for the company, but

her home was about 300 yards from the plant. The daughter who had worked in the plant remains perfectly well. An employee of a neighboring cemetery, about one half mile distant from the plant, came down with the disease. His work was in the crematorium. He had also worked evenings as a janitor in a nearby leather factory. He had never worked for the company.

#### NECROTIZING TISSUE

Sarcoid lesions have been found in certain patients with neoplasms. For example, in another locality, a patient was operated on for suspected abdominal pathology. A gland was removed, which showed sarcoid. The patient died a few months later; autopsy revealed that she died of Hodgkins' Disease. It may be mentioned that Hodgkins' Disease is malignant granuloma, while sarcoid is benign granuloma. Sarcoid involvement of lymph glands has not infrequently been reported as appearing in cases of carcinoma and other types of malignancy. Sarcoid has, therefore, been believed to be associated with conditions where necrosis of body tissue, especially malignant tissue, has existed. This cue has been followed up, but did not fit our problem.

#### ALLERGY

The question of allergy has been considered. If an exposure was in 1941 and 1942, a shocking dose may have been received some years later and the disease resulted. That question has arisen in connection with certain chemicals, but again we have not been able to fit it in. Most of the patients were not exposed to phosphors at the time that they came down with the disease, as one would have expected in allergy from that source.

#### CHEMICAL AGENTS

A chemical cause of the disease must be seriously considered, inasmuch as many chemicals were involved in the manufacture of fluorescent lamps.

Each chemical in use has been listed, its toxicology noted, and where suspicion arose, animal experimentation done. Thus, illuminating gas, barium carbonate, red phosphorus, cryolite, bakelite (as skin rashes have occurred, it was probably completely polymerized), denatured alcohol, dimethylphthalate, amyl acetate (which turned out to be a vaso-constrictor of the nasal mucous membranes and to relieve sinusitis), butyl acetate, toluol, xylol, solder, tungsten, copper, nickel, mercury, thorium, cadmium, selenium, sodium fluoride, and carbon

disulphide were each investigated without finding a lead as to the causative agent.

The phosphors received our special attention. The commoner phosphors in use were zinc-beryllium-manganese silicate, magnesium tungstate, magnesium silicate, zinc silicate (Willemite), cadmium borate, and lead fluoride. These powders were processed in another plant of the company in a different state and two cases of sarcoidosis were found there. One occurred two years after all exposure to fluorescent powder manufacture; he had worked on tungsten wire production since that time. The other, a maintenance man, also had not worked directly with fluorescent powders for over two years, although he had been in the building occasionally. Two cases outside the company have been reported in sign tubing workers. Of the other companies manufacturing fluorescent lamps and powders one reported two cases of sarcoidosis in their experimental laboratory unit, but none reported difficulties among their manufacturing personnel. Circumstantial evidence against the phosphors seemed to be accumulating.

Silicosis was first definitely considered and ruled out. Silicates have not been recognized as causing silicosis; nor did they cause silicosis in the experimental animals in the studies with phosphors. In the analysis of fluorescent powders a very small percentage of cristobalite has been detected; cristobalite is a type of crystallized silica (quartz) which is very prone to lead to silicosis. There is a possibility of an unusual type of crystallized silica causing the disease, with maximum reaction to minimum amounts. But in silicosis, the x-ray shadows precede the symptoms by many months. Also the shadows tend to migrate toward the hilum—a condition not seen in sarcoidosis. Analysis of lung tissue, obtained at necropsy did not show silica in more than normal amounts. The clinical story is also not that of silicosis.

Magnesium tungstate was not found to be toxic to animals, either by aspiration, by mouth, or by injection. Cadmium borate is toxic, but its use in the manufacture was very limited. It is a liver poison and does not lead to lung pathology.

Willemite will lead to acute pneumonitis if inhaled in sufficient amounts; the same may be said for zinc oxide, zinc carbonate, and other zinc preparations. Zinc oxide is, as a matter of fact, a greater pulmonary irritant than corresponding beryllium oxide powder. Sarcoid has not been reported in the zinc industry except in one brass foundry in Waterbury where



beryllium was also used.

Most attention among the phosphors has been directed toward the zinc beryllium manganese silicate and especially to its beryllium component. This substance may be a chemical compound or it may be of the nature of a glass surrounding a mite of silica. It is made by mixing beryllium oxide, manganese oxide, zinc oxide, and silicic acid. The mixture is heated in a furnace at a temperature in excess of 2,000 degrees. This causes the substance to unite into the compound or glass and to take a crystalline instead of an amorphous characteristic. The powders are of small size, approximately from .4 micron to  $1\frac{1}{2}$  microns. The smaller the particle size, the better the fluorescence one obtains. At about the time the first of the sarcoidosis cases came to our attention, there were five definite cases of acute chemical pneumonitis which appeared in employees who were working with zinc beryllium manganese silicate but not in the plants where the thirty-three of the thirty-five patients worked. The individuals had considerable exposure to the dust of this phosphor. The disease appeared in at least three of the cases within two months after coming to work for the company. All of the persons showed complete recovery after three months; in fact, two of the employees later were in the armed forces, one of them as an airplane pilot; thus, appreciable permanent injury seemed unlikely. The nature of the pathology was edema of the interstitial tissue of the lung, a condition similar to that seen when other irritants are breathed. The similarity of these cases to those from nitrogen oxide fumes as in the Cleveland Clinic x-ray disaster is striking. One of the patients, two years later, developed sarcoid.

Also at about the same time there were a number of cases of severe acute chemical pneumonitis in plants where beryllium processing was being done. The evidence in these cases points to the pneumonitis not being due to beryllium but to hydrofluoric acid or sulfur trioxide which were released into the atmosphere during the chemical processing. In one plant where there were several cases, the incidence of the pneumonitis ended abruptly when a different chemical procedure was used to change beryllium sulfate into beryllium oxide. This acute pneumonitis is clinically and roentgenologically a distinctly different entity from sarcoid.

We have been unable as yet to fit in the manganese component of the zinc beryllium manganese silicate into the pathological picture. Manganese is funda-

mentally a vascular or nerve toxin, and no relation to granulomatous formation has been found or reported.

The question will naturally arise as to how this phosphor may get into the system to cause the disease, and naturally the first thought is that it may be taken in by aspiration of the powder. The powder is very fine and could easily be aspirated into the lungs if the person were exposed to a sufficient concentration. Considering the work of the different individuals, it is, however, quite definite that the incidence of sarcoid is not proportional among the plant workers to the severity of the exposure to fluorescent powder dust. Two individuals who never worked with fluorescent lamps or powders came down with the disease. Others who had considerable exposure did not come down with the disease. In general one may say that the affected individuals represented a fair cross section of the total workers in the plant and were not weighted on the side of those who were more exposed to fluorescent powders or beryllium. The nature of the lesions in the lungs was not exactly typical of aspiration foci but suggested rather blood-borne foci. Chemical analysis of the lungs of the patients who had died did show some beryllium present. It is difficult to interpret whether the small amount found chemically on analysis of the lungs represents a real toxic amount, merely an exposure to a small amount of fluorescent powder, or an error in the analytical methods for small amounts of beryllium. It is very difficult to get a satisfactory quantitative analysis of beryllium. The spectrographic method which is the most delicate has not proven quantitatively satisfactory in our experience.

The amount of dust in the plant was not what one would call great. The dust counts averaged under one million, quite as low counts as found out of doors. The quality of the lamps would suffer if dust got inside the tubes; therefore, special care was taken to keep the floors, walls, and machines clean. Occasionally, a tube would break and for about 15 seconds, a local cloud of dust would appear. But in general, one must admit that the plant was not dusty.

Experimental work has been done on the toxicity of beryllium to animals. Beryllium sulfate is quite toxic by reason of the anion; beryllium is a weak base and when combined with strong acid radicles as the sulfate or the fluoride, the resulting product is very acid and hence toxic. Beryllium oxide and silicate, however, are found only mildly toxic. In vari-

ous experiments where fluorescent powders had been given by injection, by mouth, and inhalation no lesions suggestive of sarcoid have been noted either in rats or rabbits.

Dr. Gardner recently has reported the occurrence of osteosarcoma in rabbits to which intravenous injections of beryllium oxide or zinc beryllium manganese silicate were given. Similar findings did not occur in other animals.

It has been noticed that attached to certain beryllium ore there has been found particles of uranium ore. This uranium ore is radio-active. The question of the possibility of the isotope of beryllium which is radio-active and which may have been present in certain of the powders used in 1940-1942 has arisen. Whereas it is quite rare that the manifestations of chemical poisoning appear in an acute phase several years after the exposure to the poison, this has not held true with a radio-active material as radium. Therefore, the possibility of radio-activity in the phosphor has come to our attention and careful observations have been made to establish the possibility of this cause. Various lots of beryllium oxide and fluorescent powders have been tested for radio-activity, as have the various parts of the buildings where fluorescent lamps have been manufactured. No radio-activity, however, has been found. It has been noted elsewhere that in cases where uranium has been processed in beryllium oxide crucibles at high heat pulmonary disease has been reported. It is also known that in the breaking down of the uranium atom, beryllium may be one of the products formed. This subject needs further study.

In summary, it may be said that there is considerable circumstantial evidence that beryllium is the responsible agent in the causation of sarcoidosis by reason of the association of sarcoid cases in industries using beryllium. However, there is still lacking proof that beryllium or its compounds will cause lesions similar to the sarcoid lesions found in the thirty-five patients described. The prolonged waiting period is not in keeping with the usual behavior of the acute phases of chemical poisoning.

A suggestion and working hypothesis of Dr. Gardner has been that two factors are necessary in explaining the etiology of the disease, as infection and beryllium.

The material presented in this paper represents the observations, studies, and thoughts of a number of people over a period of at least four years. Special mention should be made to the work of Dr. Leroy

U. Gardner of the Saranac Laboratories. He has contributed much, especially in his experimental observations as to the toxicity of various chemicals used in the making of fluorescent lamps. He has also been of distinct value in correlating the experiences of private physicians and various industrial plants where sarcoid has occurred or beryllium has been processed. We all regret his recent death; it had been planned that he be here to present this subject to you today. Among other workers who have made definite contributions to the subject are Dr. Timothy Leary, pathologist; Dr. Ralph E. Wheeler, bacteriologist; Dr. Ralph D. Leonard and Dr. E. A. Wilson, roentgenologists; Mr. Russell Tirrell, safety engineer; and a large number of physicians who have had these patients under their care.

From a public health point of view, it naturally appears desirable to be able to spot cases while they are still in the acute stage. Since the acute phase of the disease will appear and pass within two months, it is hardly feasible to run a periodical x-ray program for all employees sufficiently often to pick up the early cases. It occurred to us that such information might well be obtained by spotting employees who showed a marked loss in weight, and where suspicion pointed toward possible sarcoid, an x-ray could be taken to confirm the diagnosis. Therefore, at the present time, a Weighing Program has been instituted in the plants where fluorescent lamps are being manufactured. Each individual has a card with his name and height. His normal weight is also recorded using the simple normal weight formula that a person five feet tall should weight 110 pounds, five pounds being added or subtracted for each inch over or under that height. Each individual is weighed once a month in the dispensary. This affords the nurse an opportunity to observe each employee once a month, and where she suspects anything wrong, there is an opportunity for her to ask questions. Although only one case of sarcoid was picked up by this method, it has proven to be a valuable health measure in that it draws the attention of the working person to his physical status, to a tendency to become overweight or underweight, and it stimulates in them a consciousness as to their health status. Many, thus, choose to visit their own doctor or to consult the plant physician.

If you were physician in a plant where there were eight hundred people working, and there had been thirty-three cases of a puzzling disease that had appeared without clear understanding as to its cause



or how it happened, would you be willing for your daughter to go to work in that plant? That is a question that I repeatedly ask myself. I also have asked it of Dr. Gardner, of the Public Health authorities, and others. If the answer is "no," a distinct responsibility is placed on us in accepting other people to work in the plant. Should the plant be closed? We have hesitated to do this, for if we do close down the plant, it is going to be a calamity to the town in which the plant is, and will throw a lot of people out of work. The conclusion has been that since nobody hired since September 1942 has come down with the disease, and since the incubation period of the disease for those hired since that time (say to November 1943) would have passed by now (November 1946) in over 75 per cent of cases (compare Table II, line 3), it is statistically

unlikely that cases from this group will appear and probable that the causative agent is removed.

Consideration has been given to a change from beryllium phosphors to some other phosphors that may not be toxic. But that will require research and will take time. It is possible and may be done.

We are accepting these cases for workmen's compensation benefits by agreement, with the qualification that it is not known or agreed as to the name or the cause of the disease. It appears the right thing to do to accept the responsibility of paying compensation.

However, certain difficulties are met in trying to decide whether a person is wholly incapacitated or partially incapacitated. My opinion is that a few are partially incapacitated, or not incapacitated at all, whereas the employee feels otherwise.

## RAGWEED POLLEN SURVEY IN CONNECTICUT

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### DESCRIPTION OF POLLEN

Since ragweed is the most common offender in hay fever in the United States, most of the studies of pollen counting have involved the amount of ragweed in the air. From the standpoint of allergic importances in the eastern section of the country, the two significant members of the ragweed family (Ambrosiaceae) are the short or common ragweed (*Ambrosia elatior*) and giant ragweed (*Ambrosia trifida*). Short ragweed is much more abundant in Connecticut than giant ragweed.

Short ragweed has also been called dwarf ragweed, low ragweed and small ragweed. Short ragweed is a grayish-green annual, branched, averaging from one to five feet in height, with finely divided leaves, and numerous long spikes of staminate heads. Short ragweed grows in empty lots, along roadsides and even in the broken curbs and between rocks along city streets. It flourishes at the edge of cultivated fields and in grain fields after the grain crop has been harvested.

Giant ragweed has also been called tall ragweed, high ragweed and large ragweed. Giant ragweed

SINCE the days of Blackley (1855-1873), the relationship of pollen in the air to symptoms of hay fever has been known to the medical profession. Blackley, himself, suffered from hay fever. He exposed lubricated slides for twenty four hour periods, counted the number of grains that fell on them and correlated the number with his own symptoms. During the years, 1875-1876, Elias J. Marsh demonstrated ragweed pollen in the air in studies in New York City and in New Jersey.

For a period of about forty years, very little was done to further these studies. However, in 1917, at the beginning of the modern era of allergy, Scheppegrell rekindled an interest in pollen counting. Scheppegrell exposed slides smeared with various oils and glycerin mixtures. The slides were set out in different positions, some horizontally, some vertically and some in oblique positions. He reported pollen counts, using stationary locations and with slides attached to weathervanes.

grows, as a rule, along ditches and in river-bottom land. It may grow as high as twelve to fifteen feet.

Under the microscope, ragweed pollen grains are quite distinctive. Their diameter averages nineteen to twenty microns. They are usually round and covered with a number of distinct spines or spikes. Under low power they resemble golf balls.

#### TECHNIQUES OF POLLEN COUNTING

Various methods have been used for the preparation of slides for pollen counting. It has been customary to use an ordinary glass slide, 25 x 75 mm. Wodehouse<sup>19,20</sup> and others have prepared slides by smearing them with a preparation of glycerin jelly and staining with methyl green. Some men have used a thinly applied vaseline preparation, which was stained with Calberla solution before counting.

Since each investigator devised his own system for estimating the number of grains of pollen, different sized areas were used as standards. Durham<sup>7</sup> originally set as a standard area 1.8 square centimeters of the exposed microscope slide. This standard was followed by a number of men. However, various other units areas were used: 1 square centimeter (Gay),<sup>1,14</sup> 1 square foot (Deamer and McMinn),<sup>18</sup> 3.5 square centimeters (Wodehouse),<sup>19</sup> 1 square inch (Rowe),<sup>18</sup> and 0.55 square inches (Duke,<sup>6</sup> Duke and Durham and Balyeat).<sup>2</sup>

#### TYPES OF SHELTERS

The simplest method has been to expose unprotected slides for twenty four hours. This, however, afforded no protection against rain or insects or large objects such as leaves. These shortcomings led to the utilization of various types of metal shelters.

Gay<sup>14</sup> used a metal shelter open on all four sides. Wodehouse<sup>19</sup> devised a metal cover, like a wide half hoop, flattened on the top and opened on two sides, with the slide raised four inches above the floor of the shelter.

The latest type of shelter, devised by Durham<sup>12</sup> and recommended by the Pollen Survey Committee of the American Academy of Allergy was used in part of the present survey and will be described below.

Various intricate mechanical types of collecting apparatus have been worked out by Erdtman,<sup>20</sup> Duke<sup>6</sup> and others. These have proven to be too complicated and have no advantages over the simpler types of shelters.

#### DISCUSSION OF PREVIOUS SURVEYS

Gay<sup>1</sup> began making surveys in Baltimore, Maryland in 1927. In that year, he set up several stations in various parts of the city. He noted that the counts varied considerably at these stations which were in different parts of the city, and at different heights of exposure. He felt that these variations were dependent upon air currents, upon the relation of the counting station to other buildings and upon its proximity to woods, fields and other pollen-bearing areas. He concluded that there was a definite correlation between pollen counts and the incidence of hay fever and asthma. In a later report covering a survey of the year 1930,<sup>17</sup> Gay found that there was not too much difference in pollen counts between the various stations that he used. He reported that the peak of that year was on September 4, 1930 with the count 112 grains in one square centimeter of surface area counted.

Reports of counts by Duke<sup>6</sup> in Kansas City, Missouri, from 1927 through 1930 revealed some interesting variations. The highest count on a single day in 1927 was 2700. In 1930, which was a drought year, the highest count was 600. He observed that ragweed pollination varied directly with the corn crop. He was of the opinion that the amount of pollen found on a slide depended upon gross wind currents; and therefore the pollen content of the air at ground level would not materially differ from the pollen content of air on the top of a high building.

O. C. Durham<sup>7-11</sup> has been responsible for the national scope of the pollen counting. Beginning in 1929, he set up pollen stations in different sections of the country which have enabled him to study the relative pollen fall throughout the United States. He has reported on seventy or more weather stations here and four in Canada. Durham's concept has been that the ragweed pollen is a national crop that can be studied like any plant crop. Its fall varies considerably with wind flow. His counts were done on a slide area of 1.8 centimeter. During the years 1929 through 1933, a five year survey,<sup>11</sup> he reported a marked variation in ragweed fall. Boston, Massachusetts had a total season fall of 58 grains in 1929, 1169 grains in 1931 with a five year average of 790. Buffalo, New York, on the other hand had a low of 3,948 during 1930, a high of 12,388 in 1932 and a five year average of 8992. New York City's total fall varied from a low of 1100 in 1930 to a high of 2643 in 1931 with an average total fall



of 1606. The counts at other stations are just as interesting and as enlightening as these.

Durham drew some very interesting conclusions. He noted that short ragweed was by far the most common pollen found through the country, with giant ragweed next. The ragweed crop usually depended upon the amount of rainfall during June and July, although this did not hold true in 1933 when the rainfall was average but the pollen count was the heaviest ever. He estimated that the total 1933 ragweed crop in the United States was over 275,000 tons.

Wodehouse<sup>19</sup> reported a pollen survey made at Yonkers, New York in 1932. His counts were carried out on the top of a building five stories high. The elevation was used to gain general average conditions by avoiding the effect of immediately local vegetation. In his opinion, this was preferable to having counts overbalanced by pollen from plants of the immediate vicinity as would be the case at ground level. His chart revealed the various pollens in the air each day from March to October.

#### PRESENT SURVEY

The present survey consisted of a three year study carried out during 1944, 1945 and 1946 in Waterbury, Connecticut, a typical New England manufacturing city of 100,000 population. It is a hilly saucer-shaped city, surrounded by several small villages, suburbs, and small farms. The location selected for the pollen station was the roof of a local hospital, four stories in height, set on a hill in the western section of the city.

The technique used the first two years differed from that used during the third year, as will be explained, but a method of comparison correlated the results of the two techniques.

During the first two years (1944 and 1945), the shelter consisted of a platform  $8\frac{1}{2} \times 8\frac{1}{2}$  inches with a curved metal roof  $3\frac{1}{2}$  inches high at the center. Two sides were completely open, the other two sides had openings  $3\frac{1}{2}$  inches high by 4 inches wide. The slide, covered with a preparation of glycerin jelly and methyl green, was set in the center, on the floor of the shelter.

The third year (1946), the study was carried out in collaboration with the National Pollen Survey Committee of the American Academy of Allergy. The method previously used was changed to the standard recommended by the committee. A sampl-

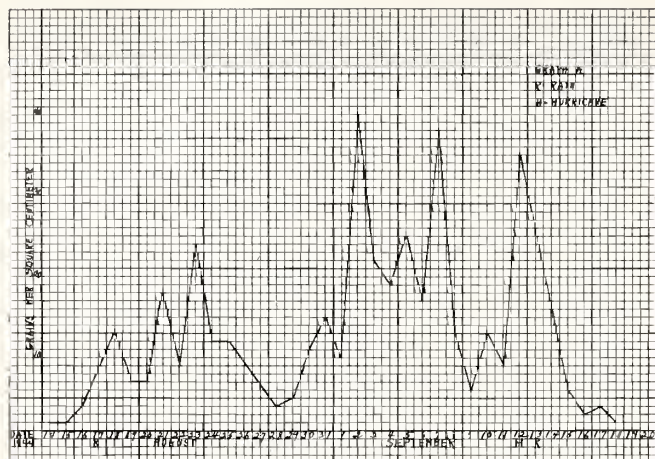
ing device was used which consisted of two nine inch, heavy, polished, stainless steel discs set horizontally three inches apart and held with three struts. One inch above the center of the lower plane was placed a slide holder into which the slide fit snugly. The supporting rod of the apparatus, thirty inches long, rose from a tripod base attached to heavy crossed boards to keep the apparatus firm. The slides were smeared with a mixture of 75 per cent petrolatum and 25 per cent mineral oil. Just before counting, the slide was stained with Calberla's solution and the pollen counted through a cover slip, 22mm by 22mm. The whole area (4.84 square centimeters) under the cover slip was counted. Dividing by 4.84 gave the average number of pollen granules per square centimeter. Slides were exposed for a period of twenty four hours, and were changed each morning at approximately 8:30 A. M.

In order to correlate these results, two factors had to be considered: the change in the size of the unit area and the change in the type of shelter. By multiplying with the factor 0.6, the results obtained with the unit area of 1.8 square centimeters during the first two years of the series were corrected to conform with the results of the third year, when the unit area of 1 square centimeter was used. In order to correct for the change in type of shelter, counts were made during 1946 using the older shelter as well as the new one. It was found that the older shelter gave counts approximately four times greater than the Durham type of shelter. Therefore, by dividing by four the figure obtained in the unit area correction, a final correlation was achieved.

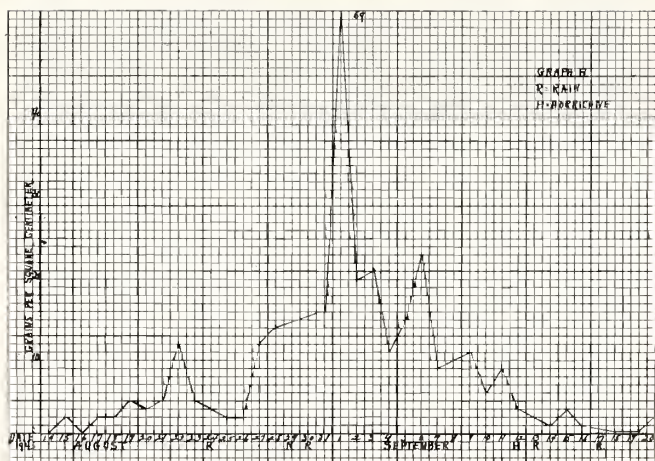
#### ANALYSIS OF THE SURVEYS

Total pollen counts, corrected to the 1946 technique (which will be the standard used in the future) were 393 for the year 1944, 275 for the year 1945. The count was 273 for the year 1946. None of these counts are extremely high. Those of 1945 and 1946 were definitely lower than that of 1944. During the three years, it was noted that the ragweed appeared slowly between the 15th and 20th of August, gradually increased, usually hit its peak about Labor Day, and fell off between the 14th and 20th of September, after which no ragweed was found in the air. In 1944, there was a definite spill of ragweed pollen grains between the 20th and 25th of August, which did not occur in the following years. Reference to the 1944 graph reveals three peaks during September, each reaching almost 40 grains. In 1945, aside from

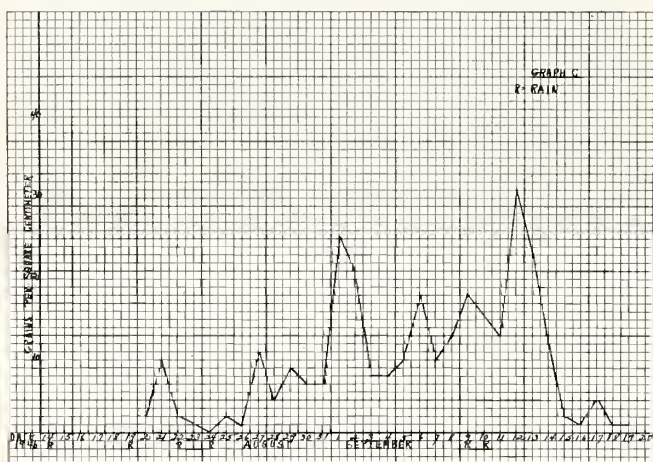




GRAPH A-1944



GRAPH B-1945



GRAPH C-1946

a very high peak, which occurred on September 1, the day of the hurricane, there was only one other smaller peak of 22 grains. In 1946 there were only two low peaks. Observation of the graphs B and C reveals that during neither of these years was the ragweed count very great.

In 1946, an almost solid period of rain from August 14 to August 25, as revealed in graph C, occurred at the time when ragweed was ready for pollination. Instead of the usual mid August rise, only one small twenty-four peak occurred during a two day sunny spell. The entire 1946 pollen crop was thrown off by this poor early season start.

#### DISCUSSION

Pollen counts have been made for many years by many different techniques. This year, 1946, a standard technique including the exposing device, the counting area and the preparation of the slide was recommended by the National Pollen Survey Committee of the American Academy of Allergy.

It will be of inestimable value in the future to have a common standard that all workers can use in reporting pollen counts, whereby one series of studies can be directly compared with another. For that reason, our counts made during 1944 and 1945 were corrected to conform with the new system.

A study of our graphs reveals a certain periodicity in average spill of pollen grains. A peak in this section of the country usually occurs around Labor Day. An extended period of rain at this time can diminish the ragweed pollination in the same way as it can the corn or grain harvest.

Pollen is not the only factor causing the symptoms of pollen sensitive patients. Patients may sneeze or wheeze during the pollen season due to other causes, particularly, food and other inhalant-allergies. However, the pollen count can be used as a gauge for determining the relationship of allergic manifestations with the pollen in the air. With daily pollen counts, the occurrence of a relative increase of pollen in the air may explain why a patient may have an exacerbation of symptoms on any particular day.

Pollen counting, if performed annually, reveals large variations in ragweed pollination. Both 1945 and 1946 were poor years for ragweed pollination with low total pollen counts and low peaks. Clinically, pollen patients did relatively better during these years than in previous years. They had fewer bad days, and even on those days they were not as uncomfortable as during previous years.

One cannot rely entirely upon the pollen graphs since they give only a general estimate of the amount of pollen in the particular region. We may find individual cases doing poorly notwithstanding a low



pollen count although all other factors have apparently been controlled. A close investigation often reveals that the patient is living in close proximity to a large field of ragweed with prevailing winds blowing towards his home. There were some patients with worse ragweed hay fever this year than during any previous year. Questioning disclosed that they had moved from the business center of the city to the outskirts where ragweed was present in relatively large amounts.

#### SUMMARY

1. Ragweed pollen surveys were made in Waterbury, Connecticut during the years 1944, 1945 and 1946.

2. During 1944 and 1945, an old type roofed shelter was used. In 1946, a new Durham shelter was substituted.

3. Factors were used to correlate the surveys of the three years.

4. Ragweed pollen counts during 1945 and 1946 were low.

5. It is advantageous for all workers to use the same technique for collecting and counting pollen. This standardization would simplify a comparison of future studies by different investigators.

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## THE CONNECTICUT CANCER RECORD REGISTRY—HOW IT FUNCTIONS

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THE HISTORICAL development of the idea of the cancer record registry has been presented in a previous paper before this group. This report will describe the practical details involved in establishing a record registry in an individual hospital, and in the methods by which the material abstracted from the hospital chart to the tumor record form is processed and used. Certain essentials were available to the Division of Cancer and Other Chronic Diseases before the systematic collection of records was begun. A survey of every case hospitalized for cancer in the state had been made for a 12-month period, so that the expected number of cases could be estimated. Three hospitals had evolved record systems of their own in which a separate file of cancer cases was kept. The Yale University School of Medicine had established its registry and had made the results of its experience available to the Division of Cancer and Other Chronic Diseases. The Tumor Study Committee of the Connecticut State Medical Society, one of the most active in the Society, had blazed the trail by arousing interest throughout its membership. There was an Association of Tumor Clinics which was becoming increasingly active. A pathologists' association was active and interested and had agreed upon uniform interpretation of reporting and grading tumors. The hospital superintendents had been interviewed and all of them were interested. Accredited medical record librarians are employed in most of the hospitals and they had featured speakers on cancer records at their annual meetings for several years before the real systematization of cancer records began. The public had been awakened through the educational efforts of the State Department of Health. In fact, every part of the population of the state had been reached. Those groups most concerned had been organized

for a united effort and the results demonstrate what may be accomplished by careful planning, a sound program and complete cooperation.

Since the establishment of a record registry in a local hospital requires the combined efforts of many of the hospital personnel and the Division of Cancer and Other Chronic Diseases, meetings are scheduled at which the whole plan may be gone over with as many of the staff as possible. The hospital administrator is interviewed first and the registry in the state office is described. He is told that the Division of Cancer and Other Chronic Diseases is trying to obtain a complete roster of every hospitalized cancer case in Connecticut from 1935, to determine the present status of each case, and to effect systematic follow-up of each one. Two trained workers from the Health Department will be available to check every admission and to make out the charts for cancer, the leukemias, Hodgkin's disease, papillomata of the bladder, and to abstract them to the standard record form. Carbon copies will be made for the state file and the originals will be retained in the hospitals as the local record registries of cancer cases. The superintendent is asked to assign one record worker to the task of abstracting so that she may spend some time with the state workers and be instructed in the correct way to fill out the standard record form. Often this worker would be the medical record librarian or her assistant. Frequently the superintendent asked how these records might be used immediately for the good of the hospital. It was arranged to tabulate the month and year of admission of patients, and upon request and at short notice, the tally of cases by site for any fiscal year can be prepared for any hospital. In Connecticut, each month begins a fiscal year for some hospital.

As a second immediate use, the Division of Cancer and Other Chronic Diseases offered to make available tables showing volume of cases, microscopic proof by year, survival by site and other pertinent data in mimeographed form with discussions for



clinical staff conferences. This has been one of the most widely used services offered.

The record form is standard letter size, is unlined to eliminate the constant adjustment of typewriter carriages, is a combination of a hospital chart and a clinic record, and has suggestive headings with room enough to give as much detail as is wanted. Follow-up sheets are of the same size and similar in set-up to the back of the original record. The form is so useful and gives such scope for the inclusion of essential data needed in epidemiological research that it has been adopted by many states at this moment and requests for information as to its use and format come in nearly every week.

A mimeographed list of all the conditions for which records should be abstracted, together with a list of all the benign neoplasms for which no records are required is given to the worker at the hospital when she is instructed in the use of the record. A detailed list of what is wanted in each heading on the record is also given to her for reference. This instruction sheet has been requested in quantity by many hospitals for use by its interns in obtaining histories.

Usually while the record workers from the Division of Cancer and Other Chronic Diseases are in an institution, the whole purpose and method of approach is taken up at the clinical conference of the medical staff and the chief and research statistician are present to discuss it and answer questions. Not infrequently, the nursing staff of the hospital is assembled and instructed in the same manner.

After the complete roster of records is abstracted, the state workers check them in the Bureau of Vital Statistics in the State Department of Health as to fact of death. The dates of death are returned to the local hospital together with the list of those not found to be dead. The workers in the local hospitals then receive what is known as the Tumor Clinic Secretary's Handbook which gives ways in which follow-up of cases may be established. First the physician who treated the cases is sent a list of his patients with the diagnosis and the last date on which each patient was known to the hospital. He is asked to ascertain the status of the patient's health. If the physician has lost track of the patient, permission is sought to trace the patient through the record office. There have been no objections to this practice. Letters are then written from the models given in the Tumor Clinic Secretary's Handbook. These letters are the ones that were found to bring

results after hundreds of letters were tried out in two hospitals, the New Haven Hospital in New Haven and the St. Francis Hospital in Hartford. If these letters do not elicit replies, social service traces the patients of the larger institutions. In the smaller hospitals the Tumor Clinic secretary frequently goes out herself, or contacts the visiting nurses association to check the patient. Since 1941 over 1,500 individuals were brought back under observation who had been hospitalized from 1935 through 1939 and who had never been contacted from the time they left the hospital after their initial treatment.

The hospital thus organized often found itself in need of a follow-up clinic, if one had not existed before, because so many individuals had lost their regular physician to war duty and the individuals as well as the hospital wanted a clinical check. Several of the active clinics in Connecticut have begun in this way, and developed into rounded diagnostic, treatment and follow-up services. The hospital staff, once a registry is begun, continues abstracting the charts of every patient admitted for the conditions sought and sending the carbons to the state office at intervals varying from every day to every few months. Each follow-up item is also typed in carbon and the carbons arrive with the records at intervals. Because the staff is small, and because the contact is closer by frequent exchanges of information, this method is recommended for its efficiency. Tabulations are made daily in the office of the records and follow-up notes as they are received from each hospital. It is possible to look back to 1942 and tell for each hospital how many records and follow-up notes arrived and on what day. When this calendar of receipt of records and follow-ups is totalled, an immediate measure of progress becomes available. In 1943, for example, 3,120 records and 3,873 follow-up items were received. In 1945, 4,710 records and 10,610 follow-ups were received. Through October 1946, 4,262 records and 11,244 items of follow-up have been received.

After the records are entered in the book, cards are made out and filed in the alphabetical index. If the patient is a second admission for a given cancer, this information is added as follow-up to the first record; if the patient has a *second* cancer, the date of the second admission and cancer is added to the original index card; if the patient is secondary from some other hospital and there is an index card from the first hospital, the new index card is tabbed and filed beside the first one and a note is placed on the

record that it is to be abstracted and sent as follow-up to the first hospital. This system has saved untold hours of time for social workers and visiting nurses. Ten per cent of all cases in Connecticut go to more than one hospital in the state during the course of their disease. This is explainable by the fact that there is an exchange between institutions which do not have radiation facilities and those which do. Some cases have their initial treatment in one of the centers and their terminal care in a smaller hospital nearer home.

The code that has been selected for the identification of the cancer is then added. In Connecticut two codes are entered on the record and on the punch card and a study is being made of the relative merits of each. The first is the standard nomenclature with some minor changes decided upon by the Tumor Study Committee, and the second is the Nomenclature of Diagnoses for the Memorial Hospital in New York City. Two codes are also added for purposes of comparison on the histological type of the cancer, one is from the standard and the other is the Warren classification. A third code, and one of which Connecticut is rightly proud gives the quality of tumor diagnosis and grade. This is the result of the uniform plan agreed upon by the Pathologists' Association. This code number is added to the standard record form by the pathologist in the local hospital. The importance of a consistent histological code cannot be over emphasized. It has been found convenient to code the records directly on the original record form. Two rubber stamps have been made; the first with the numbers one to 40 and the second with the numbers 41 to 80, arranged in a column. The first is added to the extreme left of the record and the other close to the margin on the right. A worker has been trained to place the numerical values for the several items sought beside the appropriate number in these columns. The records are immediately punched, checked and filed by site. The punch cards are kept in numerical order by site by hospital. If follow-up information changes certain facts on the punch card, the original punch card is withdrawn and destroyed and a new one is punched. At any given moment the records are up to date as far as the information is in the office. One or two hospitals send in their follow-up at six-month intervals; all the others as rapidly as they obtain it.

There are 52 columns on the punch card that makes possible tabulations for items which are the

same for every kind of cancer. The other columns on the code and punch card beyond that point differ according to site. Besides the facts mentioned above the usual information is coded for age, sex, nationality, duration of symptoms, present status, town and county of residence, date of death, private, ward or clinic status, marital status, color, occupation, primary or secondary admission, stage of disease on admission, general condition on admission, hereditary history of cancer and whether it is of the same site, red and white blood counts, serology, treatment, and autopsy. This code worked out and found to be effective has been adopted by other states together with the record form, so that the time is not far off when a group of states will be able to report comparable statistics.

The separate record registries have all been established in this way. The principle is simple and the method of carrying it out is readily applied. The easy exchange of information between the state office and the local hospitals makes a steady contact. The state is small and this facilitates matters. There is hardly a physician in the state who has not been written to about at least one patient. There have been over 35,000 admissions to Connecticut hospitals in 11 years for the first time for cancer and Connecticut has a population of under 2 million. The most encouraging and educational single feature of the whole plan was the determination early in the organization period that there were thousands of five year survivals. Many of these had cancer and many were cures but that there were so many alive who had had cancer was a positive demonstration that was unequalled in importance in stimulating renewed interest. There are now functioning registries in 28 hospitals; three more have been contacted and beyond that there are four to be completed. These are the smallest hospitals in the state. Shortage of personnel is the factor that has prevented the completion of these few hospitals before this. Several hospitals in surrounding states are voluntarily abstracting to the Connecticut record form the histories of admissions to their institutions of residents of this state and sending them to the Division of Cancer and Other Chronic Diseases. Follow-up of Connecticut residents is returned to the State Department of Health from many of the states of the union. One is a memorable case of a Connecticut resident who moved to California and wrote home in anxiety about her post operative care. The State Department of Health wrote to a physi-



cian in San Francisco with whom we had a contact and told him about the case. He contacted the woman, and returned a clinical report to Connecticut which was received just 28 days from the day the woman arrived in California.

A regular practice is being made of reporting to the hospitals requesting it, detailed tables of their own experience. Sixteen such reports were made last year. The systematic checking of the death records in Connecticut with the clinical records has given now over eleven years of comparative records which are being checked for accuracy, against one another.

Detailed studies of cancer by site are now under way. The second study is being made on cancer of the prostate. A detailed study on cancer of the rectum was recently reported from these records by Dr. E. J. Ottenheimer before the New England

Surgical Society.

It is anticipated that from now on analysis of one factor after another from these records will result in a series of data of real significance because it will be statewide and representative. That this registry is typical of the whole picture is evidenced by the proportions of the several kinds of cancer. Fourteen per cent of the total cases are cancer of the breast, five per cent cancer of the rectum, and so on, in the known ratio of cancer by site.

The record registry has been developed in Connecticut into a source of accurate information about the incidence of cancer, as well as into a tool in the establishment of follow-up of all cases of cancer. Its epidemiological implications are being explored. It is simple in concept, relatively direct in its approach to cancer and possible of adaptation to any state in the country.

## THE CONTRIBUTION OF YALE UNIVERSITY SCHOOL OF MEDICINE TO THE CONNECTICUT CANCER PROGRAM

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CONNECTICUT, the third smallest of the states, with an area of five thousand square miles is a compact and well integrated unit of the population which has served throughout its history as a pioneer in the development of civic, sociological and industrial advances. In 1701, Yale College was founded.

"The initial organization of the School of Medicine was completed in 1812 following the passage of a bill by the Connecticut General Assembly in 1810 granting a charter for "The Medical Institution of Yale College," to be conducted under the joint supervision of the College and the Connecticut State Medical Society. This institution was formally opened in 1813, and the first degrees were conferred

the following year. In 1884, with the approval of the Medical Society, the original charter was amended to place the school definitely in the control of the College as the Medical School of Yale College. The name Yale College was changed to Yale University in 1887, and the name of the Medical School was automatically changed. The present name of the school was adopted in 1918.

Shortly after the establishment of the school, members of its faculty and physicians in the State joined with other citizens in raising funds for a hospital at New Haven to provide, among other services, clinical facilities for the instruction of medical students. The outcome of these efforts was the incorporation of the General Hospital Society of Connecticut in 1826, and the opening of the New Haven Hospital in 1832. The establishment of the New Haven Dispensary followed in 1872. Through

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*From the Tumor Registry of the Department of Surgery, Yale University School of Medicine. This study was aided by grants from the Jane Coffin Childs Memorial Fund for Medical Research*

*Presented at the third annual meeting of the Public Health Cancer Association, Municipal Auditorium, Cleveland, Ohio, November 11, 1946*

agreements with the governing boards of these institutions, clinical instruction was made possible."<sup>1</sup>

Two distinct trends have occurred in the development of the cancer program in Connecticut. One is that phase which is more properly classified as abstract and applied research, which has emanated from the Medical School, and the other is the broad field of organization, administration and correlation of medical, diagnostic, treatment and educational facilities. When these two trends came together as a common effort, the Connecticut Cancer Program may be considered to have begun.

#### RESEARCH

The new and radical addition of roentgenology to cancer therapy and diagnosis which was discovered in the last decade of the nineteenth century and introduced to practical use in the first decade of the twentieth century gave encouragement to all workers in the field of cancer. The contributions in essential research to cancer from Yale have appeared occasionally and with increasing frequency from the article by Dr. H. B. Ferris, professor of anatomy at Yale Medical School which appeared in 1889 in the *Yale Medical Journal* entitled, "Cell Division in Carcinoma."

By 1921, beginning with the report of Dr. T. S. Moise entitled "Primary Carcinoma of the Lung," contributions on cancer to the medical literature from Yale University School of Medicine have been frequent. Outstanding early reports were "Results in One Hundred Cases of Carcinoma of the Prostate and Seminal Vesicles Treated with Radium" by Dr. Clyde Deming, in 1922 and "The Present Treatment of Cancer" by Dr. J. J. Morton, in 1923.

The environment at Yale has been a consistently healthy one for the development of ideas in cancer research, administration and control. In 1933, a study group was formed called the Atypical Growth Unit, prominent among whose membership were Drs. Edgar Allen and William U. Gardner, endocrinologists; Samuel C. Harvey and Ashley Oughterson, surgeons; Leonell C. Strong, geneticist; Ross G. Harrison and John S. Nicholas, biologists; Donald Jones, botanist; Rudolph Anderson and Werner Bergmann, organic chemists; Dean Milton C. Winternitz, pathologist; and George M. Smith, chairman. This group encouraged the biologic studies of all the different aspects of cancer at Yale. These meetings have been held regularly twice a month during the school year since then and make possible

through the presentation of coordinated accounts of researches in special phases of the general problems of atypical growth, a realization of the innumerable facets of this problem, and the need of sharing this knowledge.

The studies conducted by this group were supported first by the Anna Fuller Foundation and were later augmented by the International Cancer Foundation, the name of which has recently been changed to the Donner Foundation. In 1937, the Jane Coffin Childs Memorial Fund for Medical Research was established. It has been under the able guidance of Dr. Stanhope Bayne-Jones from the beginning. Dr. Bayne-Jones resigned the deanship of the medical school to devote his full time to the administration of this foundation which has played a vital role in encouraging new research in cancer. Although it is not specified in its name that these funds are to be used exclusively for research in cancer such has been the main use to which they have been placed. The resources of the Jane Coffin Childs Fund may be extended wherever research of potential importance in cancer may be carried on regardless of country. It so happens that approximately half of its grants have been to research projects at Yale. It has made possible through visits of its research fellows from all over the world the absorption by the workers at Yale of many new ideas of the best work on cancer. Recently more funds have been made available to help research in this institution by grants from the Federal Government and the Committee on Growth of the National Research Council acting for the American Cancer Society. The importance of the work of this group is demonstrable in the fact that no governing board for cancer foundations in the country is without one of the original members of the Atypical Growth Study Unit.

Contributions of the faculty members of the Medical School represent many phases of the problem of atypical growth. Many studies that could not be carried on as separate entities are being conducted through collaboration between the working groups. At present, the examples of the members of the faculty actively engaged in cancer research on a part or full-time basis are: (1) Dr. Clyde Deming, interested in prostatic cancer in man; (2) Dr. Francisco Duran-Reynals, and (3) Dr. Edward Shrigley, both of the Department of Bacteriology, who are working on the viruses and the cell-free filtrates in relation to the causes of cancer—particularly in birds; (4) Professor Harry S. N. Greene, of the



department of pathology, who has developed the technique for transplantation of human and animal tumors in the anterior chamber of other species:

(5) Professor William Salter, department of pharmacology, who is studying the biochemical alterations within the body that may be associated with the origin of cancer, such as the respiratory enzymes, etc.; (6) Professor William Gardner, department of anatomy, who has been working on the endocrine aspects of the normal and abnormal physiology that may lead toward the origin of cancer, particularly of the endocrine system, such as adenocarcinoma of the breast, cervical carcinoma and pituitary adenomas; (7) and (8) Dr. Charles Hooker and Dr. Carroll Pfeiffer, of the department of anatomy, working on transplantation of testicular tumors and the influence of estrogens on the differentiation of such tumors; (9) Dr. Leonell Strong, who is interested in the genetic analysis of cancer susceptibility and the production of many types of malignancy, such as scirrhus carcinoma of the mammary gland and adenocarcinoma of the stomach which are common in man but previously had never been produced experimentally in animals. From time to time many other investigators have worked on the cancer problem with the cooperation of one of the above men.

This is a brief sketch which does not mention scores of contributors and numerous researches. It is presented in this way to highlight the broadness of the base on which the work on cancer at Yale is predicated. Many of the same men were at work in the basic research, in the clinics, and in the administrative planning for a state-wide cancer program. All these efforts were closely interwoven.

#### TREND OF DEVELOPMENT OF ORGANIZATION FOR ADMINISTERING EFFORTS TO CONTROL CANCER IN CONNECTICUT

In the fall of 1926, the Health Division of the New Haven Community Chest requested Dr. C. E. A. Winslow, the Lauder Professor of Public Health at the Medical School, to conduct a survey of the health facilities and needs of the City of New Haven. The survey, the most comprehensive of the kind undertaken at that time, included an administrative plan for cancer control by Dr. Samuel C. Harvey, professor of surgery at the Yale University School of Medicine that forms the basis for the present cancer program in Connecticut.

This plan was presented in the following four recommendations:

(1) That, unless a transfer of the whole work of

vital statistics registration to the Health Department can be effected, the Board of Health provide for a special statistical assistant to make a continuing study of the statistical aspects of the cancer problem in New Haven (and of allied topics . . .).

(2) That the Board of Health through the medium of a special Bureau of Health Education organize, with the cooperation of local physicians and surgeons, an intensive campaign of education among the members of the medical profession and the public in regard to the importance of the early diagnosis and prompt surgical treatment of cancer.

(3) That a special Cancer Clinic for the early diagnosis of this disease be opened at the New Haven Dispensary and that free consultation service in respect to this problem be offered to the private physicians of the city; and that provision be made in the dispensary budget for clerical assistance to keep the records and carry on the correspondence of the Cancer Clinic.

(4) That, if, and when, the last two steps are taken, the Visiting Nurse Association staff should be increased to provide for more intensive follow-up of suspected cancer cases, of cases diagnosed but not yet operated upon and of post-hospital cases.

All of these recommendations were effected in New Haven; the clinic, in 1929, the statistical assistant in the Health Department, in 1930, the development of a record form, statistical reporting and follow-up of cases in rapid succession.

The concentration on cancer by so many leaders in Connecticut was reflected in every part of medical life. At meetings of the Medical Society cancer was constantly being considered and the experience of the American Society for the Control of Cancer and of the state Cancer Programs beginning to function were being followed with great interest. The interest in cancer at Yale reached a point where separate files of cancer records in specified services of the New Haven Hospital were being kept and the data from these records were subjected to analysis. By 1933, when the State Medical Society set up the first Tumor Study Committee, Yale University School of Medicine had a backlog of recorded experience which was made available to this committee as a guide for its thinking and planning. Interested surgeons and pathologists in several other hospitals in Connecticut, notably the Bridgeport, Hartford and Norwalk hospitals were establishing separate cancer record files to facilitate the policy of regular check-ups for their cancer

patients. The Tumor Study Committee of the State Medical Society called together interested physicians from all over the state, and they worked out the means by which an integrated program for cancer control for Connecticut could be effected. This first group of far sighted planners anticipated the value of a complete registry of the record of every hospitalized cancer case and the establishment of the principle of universal follow-up. Samples of record forms in use in cancer were examined and tested. Members of the original committee experimented with the several record forms in their own institutions, and by the process of trial and error eventually selected the one now in use in this state.

In 1935, under the direction of Professor Ira Hiscock of the School of Public Health, a comprehensive report entitled "The Cancer Problem in New Haven" was published, which presented the problem factually, listed facilities and recommended steps for its alleviation. The same year the Division of Cancer Research in the State Department of Health was established to carry out at state level the work for which the New Haven group had demonstrated the need at the community level. The Medical Society and the small new unit in the State Department of Health worked together with the Medical School and the general hospitals in the state toward a unified and productive method of meeting the need of every part of the population in the diagnosis and treatment of cancer.

From 1935 to 1938, there was a steady though gradual increase in the establishment of cancer clinics and follow-up services in the general hospitals. The staffs accepted the record form approved by the Tumor Study Committee, and the State Department of Health supplied these forms. An association of tumor clinics and a pathologists association came into being and all became integral parts of the expanding program. In 1938, the Jane Coffin Childs Memorial Fund for Medical Research gave a grant to establish a cancer record registry at Yale University School of Medicine which served as a demonstration in one hospital of what a state registry might accomplish. Cancer clinics were held three days a week. The staff of the record registry notified patients to return for follow-up and sent out for individuals who missed their appointments so that no cancer patient would be without the necessary service. Weekly conferences were held with the surgeon, radiologist, pathologist and statistician from the registry in attendance. Problems that arose in abstracting medical records were discussed and

plans were made to eliminate confusion and guarantee uniform interpretation. The excellence of the systematization of this registry is due to the untiring efforts and enthusiasm of Dr. Ashley W. Oughterson.

All the communities in the state at work on the problem, the association of tumor clinics and the pathologists group working for an acceptable pathological classification were in touch with or represented by the group at Yale Medical School. As rapidly as a plan was recommended it was put into practice in the record registry and cancer clinic at the New Haven Hospital. This group tested on a sample basis for the state-wide group and rejected plans found in practice to be unworkable. By 1941, the record form, the plan for a registry, the mechanics of clinic management and the practice of analysis of data contained in hundreds of cancer records uniformly abstracted were all fully understood, and it was apparent by the experience in this and other institutions that the plan was adaptable and could meet the needs of the entire state. A grant was made by the legislature to the State Department of Health which enabled the immediate and systematic expansion of this record registry—cancer clinic—follow-up pattern to every general hospital in the state.

The Division of Cancer Research of the State Department of Health undertook the administrative of setting up record registries and follow-up of patients from January 1, 1935. The experience of the Tumor Registry at Yale was offered to the personnel of the State Department of Health to be used in any way in which it might be helpful in expediting the formation of adequate tumor record registries in each general hospital. The first and immediate use made of this experience was in training medical record workers in the specific field of cancer. At the medical school it was possible to demonstrate the best way of abstracting information from the hospital records for every type of cancer. By working on the records in this teaching institution, statisticians beginning to specialize in the field of cancer records were able to become acquainted in a very short period of time with practically every characteristic of cancer records that might occur. This was just one form of the integrated cooperation that has characterized the program for cancer control in the State of Connecticut.

The Yale Unit was one of the first called for service in the war. The sudden withdrawal of so many of the physicians created the need of finding new



ways of continuing follow-up of patients. The private physicians and hospital social service had been the media of contact with the patients. Suddenly, with the abrupt removal of about one in five of all the physicians in the state a new means of contact with the patients had to be devised. The Tumor Registry of New Haven Hospital was one of the two registries that tested new follow-up methods suggested by the Division of Cancer Research of the State Department of Health. Letters were composed to be sent to individuals, families, other relatives, community organizations, registrars of Vital Statistics, local health officers and other interested groups, for obtaining information and tracing patients. The first concern in every instance was the protection of the sensibilities of the patient. Letters that were effective in obtaining information were retained for use and letters which elicited no reply were eliminated. Recommended telephone calls were tried and adopted as routine procedure if they were found to be effective. The results of these experiences were reported to the Division of Cancer Research of the State Department of Health and were incorporated in the Tumor Clinic Secretary's Handbook which forms the basis of instruction in each local tumor record registry.

At the Yale University School of Medicine the cancer record registry is a potent source of training of medical students, a large number of whom remain in Connecticut to practice, and many of whom have actually become leaders in the cancer clinics of the

general hospitals not only throughout Connecticut but in many other states as well. In the April, 1946, Journal of the National Cancer Institute, the need for a rounded course of training for medical students was stressed. By meeting this need in part and by stimulating interest in cancer control in young and able men while they are still medical students, Yale University School of Medicine has made a real contribution to the Connecticut Cancer Program. The weekly tumor conferences are crowded with students. The discussions of cases are spirited and productive. The Yale Medical School and the State Medical Society sponsor a series of meetings, held every fall at Yale, called the Connecticut Clinical Congress. Every physician in the state is invited to attend, leaders in the several specialties are the speakers, and question periods are planned in every group of lectures. Cancer is featured at each of these Congresses. At the recent Congress there were six hundred and fifty physicians and numerous medical students in attendance.

Underlying this great interest is the fact that basic research is going on at this school, with the subsequent attraction of interested students of cancer from all over the world. By the example it has set of cooperation between clinicians and research workers, the teamwork within the school has extended to the State Department of Health and all the general hospitals in the state to form the harmonious and coordinated entity which is the Connecticut Cancer Program.

## THE USE OF A GLASS BUTTON IN THE TREATMENT OF ASCITES

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THE TREATMENT of ascites secondary to cirrhosis of the liver has taxed the ingenuity of many surgeons in the past. Omentopexy and the use of the kidney pelvis or saphenous vein as a peritoneal drain have been tried but have proven ill advised. Recently Blakemore and Lord<sup>1</sup> have described per-

forming an anastomosis between the portal vein and the vena cava or between the splenic and left renal veins with vitallium tubes. This operation is difficult to perform, fraught with danger and the results disappointing. Recently Crosby and Cooney<sup>2</sup> outlined a new procedure which I have employed with some modifications as described in the following technique. The objective of this procedure is to alleviate ascites by the use of a button so placed that it can drain peritoneal fluid into the subcutan-

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eous tissue of the lower abdomen. The advantages of this autohypodermoclysis are attributable to an increase in the urinary output and to the reabsorption of body fluids and proteins with a subsequent elevation of the plasma protein level, and a subsidence of edema secondary to hypoproteinemia, and to inferior vena caval obstruction.

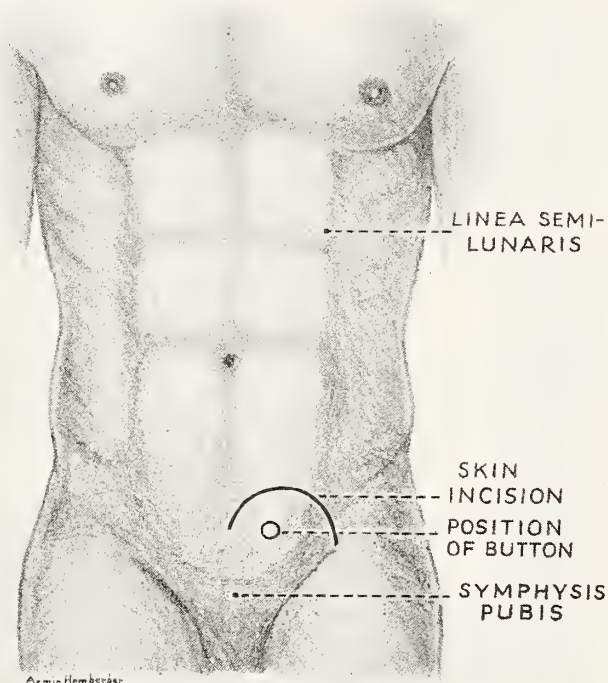


FIG. 1

#### TECHNIQUE

The operation was performed under local field block. A semi-circular incision was made over the lower aspect of either Rectus abdominis with convexity pointing upwards (Fig. 1). The skin-subcutaneous fat flap was dissected downward away from the anterior rectus sheath. A one-inch ver-

tical incision was made in the rectus sheath and the fibers of the rectus muscle separated. A small incision was made in the peritoneum, fluid evacuated and the button inserted (Fig. 2) with the platform projecting into the peritoneal cavity. The platform was constructed to prevent blockage of the button by the omentum or adjacent viscera. The button was held in place with a #34 stainless steel wire pursestring suture in the peritoneum, and a second pursestring suture in the anterior rectus sheath. The flap was then sutured with #0 catgut sutures approximating the subcutaneous fat and with interrupted silk in the skin. The incision was sealed with collodion to prevent leakage. This technique was employed in the following two cases:

#### CASE REPORTS

Case 1. A 51 year-old man entered the hospital on May 27, 1946 with a chief complaint of abdominal distention, weakness, chronic cough, loss of appetite and shortness of breath, of six months' duration.

Physical examination revealed a chronically ill man with slight pallor of the face. The liver was felt three finger breadths below the right costal margin. There was moderate tenderness but no spasm in the upper abdomen. The spleen was not palpated. A fluid wave was elicited in the abdomen which was distended. Rectal examination revealed combined hemorrhoids.

Laboratory studies revealed that the red cell count was 4,070,000; hemoglobin 75 per cent, and the white cell count 14,700. The icteric index was 20, prothrombin time 40 seconds and cephalin flocculation test 4 plus. Total protein was 6.6, albumin 3 and globulin 3.6.

A paracentesis was first performed on July 1, 1946 and had to be repeated every 5 to 7 days thereafter. Eight liters of amber-colored fluid were removed at each abdominal tap.

On July 19, 1946 a glass button was inserted in the left lower quadrant under local anesthesia. Patient withstood the operation well but died on July 30, 1946 of extensive



FIG. 2



liver disease. At no time after operation did his abdomen become distended. Post-mortem examination revealed that the liver weighed 1450 grams and was markedly cirrhotic. Only two liters of fluid were found in the peritoneal cavity.

Case 2. A 25 year-old man entered the hospital on January 19, 1946 with a chief complaint of abdominal distention, weakness and pain in the left hypochondrium. In Sept. 1943, while a member of the armed forces in Burma, he experienced a severe lancinating pain in the left upper quadrant which lasted for two days. This pain recurred one month later at which time an enlarged spleen was noted. His course was, thereafter, progressively downhill. A splenectomy was attempted in June 1944 but not performed because of marked bleeding encountered during the separation of adhesions around the spleen. Ascites was evident at that time and persisted, requiring paracenteses every six to eight days during the past two years with the evacuation of eleven to thirteen liters each time.

Physical examination revealed a chronically ill man with extensive ascites and dilatation of abdominal veins. A well healed oblique scar was seen in the left upper quadrant. The spleen was tender and markedly enlarged, extending towards the mid-line below the umbilicus. A fluid wave could be demonstrated clearly. A congenital left inguinal hernia was present and contained about 300 c.c. of fluid. There was marked edema of both legs and ankles.

Laboratory studies revealed that the icteric index was 5; prothrombin time was 35 seconds; cephalin flocculation test was negative on two occasions. The red cell count was 4,820,000; the white cell count was 4,500.

On July 6, 1946 the glass button was inserted into the right lower quadrant of the abdomen. There was edema of the lower abdomen and scrotum for one week following this operation. The edema of the ankles completely disappeared. The daily urinary output increased from 600 c.c. to 2500 c.c. and no further paracenteses were required after the operation. Improvement in his physical status was clearly evident at the time of the last check-up examination on October 25, 1946. He stated that he had a markedly increased appetite, and had gained ten pounds in the absence of any edema or of abdominal enlargement. He was considerably more robust and capable of increased activity.

#### COMMENT

The purpose of the operation is to drain the ascitic fluid from the peritoneal cavity through the button into the subcutaneous tissue where it can be absorbed. The autohypodermoclysis resulted in an elevation of the plasma proteins with subsidence of the edema of the ankles in Case 2 and in a marked increase in the urinary output in both cases. If the button should become plugged, another one could be inserted elsewhere in the lower abdomen with the minimum of risk to the patient. It is interesting to note that Crosby and Cooney<sup>2</sup> had employed the button in fifteen cases and in only one patient were paracenteses necessary post-operatively. Some of his patients had been followed for more than one year. Neither of the two cases reported in this paper required a paracentesis after the operation.

#### SUMMARY

Two patients with ascites secondary to cirrhosis of the liver have been treated by the insertion of a glass button\* designed to drain peritoneal fluid into the subcutaneous layer of the lower abdomen. The results of the procedure have been gratifying enough to warrant its further trial.

\*Manufactured by Macalaster-Bicknell Co., Cambridge, Mass.

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## AN INTERN TEACHING PROGRAM IN A SMALL HOSPITAL

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AS MORE emphasis is being placed upon certification by specialty boards, graduates in medicine are seeking internships in a teaching institution where an approved residency is in the offing. Doc-

tors returning from the armed forces account for a large number of the young physicians wishing training. These men have had at least nine months of hospital training and almost to a man prefer an appointment where an approved residency is in sight. Few of the small hospitals have approved residencies and although the internship is approved,

the future approved training of a man accepting such an internship is far off. The reason is rather obvious; namely, that the jump is a very wide one from the internship in a small non teaching hospital to the assistant residency in a teaching hospital. The teaching hospitals have a sufficient group of their own to pick from and when an outsider is appointed, he is usually from another teaching institution. For such reasons, the small non teaching hospital must meet the ever growing problem of a house staff in one of three ways. (1) No house staff; (2) Secure whatever men it can for as long as it can keep them; (3) Institute a teaching program.

#### 1. NO HOUSE STAFF

This is a bad situation. Ward patients depend for a good part of their care upon the intern staff and, therefore, suffer most. Secondly, the intern is an excellent stimulant to the attending staff on theoretical problems and a willing listener on practical grounds.

#### 2. SECURE WHATEVER MEN THE HOSPITAL CAN FOR AS LONG AS IT CAN KEEP THEM

Many small hospitals caught between alternatives (1) and (3) take a middle-of-the-road course accepting men for nine, six, or even four months—sometimes having four men, sometimes two, and sometimes one man to do the intern duties. Such a situation is conducive neither to an active teaching program on the part of the attending staff, nor to an interested participation in such a program by the interns. As a result of the stop-gap nature of such an internship, the intern rapidly adopts a devil-may-care attitude and shrugs off extra work or any of a number of inconveniences with the attitude, "I'll be out of here soon."

#### 3. INSTITUTE A TEACHING PROGRAM

In order to secure, hold, and satisfy a house staff that will in time give wholehearted and unrestrained effort and cooperation, a program based on an adequate medical training rather than financial remuneration is absolutely essential. In order that the program may even get started, certain circumstances must exist; namely:

- (a) A hospital administrator who is not only interested and willing to further a teaching program, but one who has the proper constituted authority.
- (b) An adequately trained attending staff that is willing to participate in the program.
- (c) An intern committee composed of interested

physicians and the hospital administrator who will push forward the program to completion.

When the above mentioned three conditions have been satisfied, then it is the responsibility of the resident or chief intern to arrange a schedule suitable in time to both attending and house staff. When the schedule is mutually agreeable, the intern committee may be able to arrange a residency in the hospital that will be approved. If that can be brought about, then a constant flow of new interns no longer disinterested but competing for an approved residency can easily be secured. Both hospital, attending and house staffs are satisfied and better medical care due to better trained personnel is obtained.

At the Middlesex Hospital, such a program was started October 15, 1946. Since that time, a mutually agreeable schedule has been arranged and the wheels set in motion toward an approved residency. On a basis of four interns, the following schedule which neglects no phase of training has been adopted. Each intern spends two months on each service. The services are divided:

1. Surgery, emergency room.
2. Medicine, pediatrics.
3. Orthopedics, E E N T
4. Obstetrics—gynecology, urology, personnel Health.

The intern on surgery spends one to two hours each afternoon in surgical pathology doing both gross and microscopic pathology. Medical grand rounds are held one morning each week from 8:30 to 11:00. These rounds are made by the consulting internist on service for that month. Each afternoon from 1:30 to 3:00 the intern group meets in the radiology department and with the radiologist reads the x-rays for the previous day. One hour each week the intern group meets with a member of the surgical attending staff and discusses a surgical problem. Likewise with a member of the medical staff. One hour every two weeks with a member of the obstetrical and gynecological staff. So with the urology staff and also the pediatric and eye, ear, nose and throat staff. The intern on pediatrics attends a noon clinic in pediatrics at a nearby medical center. Prenatal clinic twice a month is attended by the intern on obstetrics and gynecology. Clinical pathological conferences are held one hour a week and the intern takes an active part in presentation and discussion of cases. Tumor clinic is held one morning a month and is attended by the entire staff.



A recent step forward in securing a needed outpatient affiliation has made the outlook bright for an approved residency at this hospital. Under the above mentioned plan all who have been concerned

have prospered and grown with it. The ultimate goal of an approved residency is in sight and the solution to securing a fine house staff in a fine hospital is near.

## SCARLET FEVER IMMUNIZATIONS

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DURING THE past fifteen years much thought and several attempts have been made to inoculate against the dreaded disease of scarlet fever. Because of the severity of the reactions, which often were worse than having the disease, the method was abandoned for some time. However, during the last few years, a renewed interest has been aroused and a method used to produce what was hoped to be a permanent immunization. In 1941, at the request of the New London County Commissioners, I inoculated sixty-two children and six adults at the New London County Home using the five dose method of Lederle. This was given subcutaneously. The results of this procedure was written up in the *STATE MEDICAL JOURNAL* and later in the 1942 issue of the *Year Book of Medicine*, page sixty-nine. At this time there was a mild epidemic of scarlet fever in the vicinity of the New London County Home. A total of thirty cases were reported. This was probably the reason for the inoculations. However, one difficulty of the procedure was the inability to follow up with Dick test three weeks later as advocated by most authorities. It is interesting to note that none of the children at the County Home developed the disease so we feel reasonably sure that some degree of protection was accomplished.

During the summer and early fall of 1946 the question of inoculating the school children of the Town of Preston was raised by the authorities. As their health officer, I urged that this procedure be carried out as Dr. Eugene E. Lamoureux, director of the Bureau of Preventable Diseases, urged me to immunize the children. He very kindly sent me

down some Lederle's three dose material to use. Our first procedure was to Dick test children of Preston City School and Poquetanuck School. The results of this test showed that seventy-five per cent were positive, these ranging from six to thirteen years. In November 1946 we began the inoculation of one hundred and twelve children, receiving a total of three hundred and twenty-three inoculations, intradermally. As for the code used in checking these inoculations: (1) mild—when only a local reaction (redness) with none or slight constitutional symptoms; (2) moderate—when in addition to local reaction there occurred slight amount of fever, malaise, vomiting and joint pains; (3) severe—when pupil had to go to bed because of fever, malaise, joint pain, sore throat, and excessive vomiting. Results—mild, two hundred and ninety-five reactions; moderate, twenty-six; severe, two. Three weeks later all these children were Dick tested again with following results. Eighty-five per cent, negative; fifteen per cent, positive. Of this fifteen per cent positive, a few received the second and third dose again. They will be Dick tested later. One point of interest is the sudden death of one of the children while running along the road two weeks later. This was investigated quite thoroughly and we could find no connection between the inoculations and this sudden death. It is quite possible that this child, apparently robust and healthy, had a congenital heart lesion and died of excessive exhaustion or a persistent thymus gland may be suspected. Another point of interest in these inoculations was the fact that no child who did receive the inoculations for scarlet fever developed the disease, while a child, aged seven, who did not receive the inoculations, developed scarlet fever. However, the time interval was short and too much importance cannot be placed on this.

## COMMENT

While this series is small, I think we can learn something of the value of this procedure. Certainly reactions are not to be dreaded as formerly, due probably to refinement of the product and being given intradermally. In my opinion inoculations in the future will probably be given intradermally. In view of the fact that the State Department of Health, ever alert to useful procedures, advocates that scarlet fever immunizations be given after eighteen months of age as a routine procedure, certainly this series, however small, can be used as an argument for this routine procedure. As was expected, the majority of reactions and of the Dick tests were in the age ranging from six to ten years. This is in agreement with all authorities that this disease is much more prevalent under ten years of age than over. There is no doubt but what the virulence of the streptococcus producing scarlet fever in the last ten to fifteen years has been of low titer. To offset this it must be remembered that in some cases quite severe complications follow even after a mild case of scarlet fever. One case I have in mind proves this conclusively. This child, age four,

had a mild rash which lasted only one half a day. It was so mild that no particular attention was paid to it until a week later when child developed bilateral cervical adenitis followed by bilateral otitis media, a mild nephritis, and a mitral murmur, and all this from a case considered mild.

My sincere thanks is rendered to Miss Dorothy Peckham, the Public Health Nurse of Preston, who did most of the work in rounding up the children for these inoculations, to the public officials of the Town of Preston for considering and urging this procedure to be followed, to our State Department of Health through the courtesy of Dr. Eugene E. Lamoureux who cooperated wholeheartedly in this procedure, and to the school teachers who cooperated in making this procedure orderly.

I think this is the first attempt that has been made to inoculate all the susceptible children of a given town in the state. However, I may be wrong and may be corrected. I sincerely hope that other towns will consider this procedure which I think is of sufficient importance that they follow in this pioneer work of Scarlet Fever immunizations.

## "I SWEAR BY APOLLO THE PHYSICIAN"

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The Author. *Chief Medical Director, Veterans Administration*

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IT IS NOW a little more than 18 months since General Bradley became Administrator of Veterans' Affairs; and a little more than 16 months since I became the head of the medical service of the Veterans Administration. It is not necessary to recount to this audience the situation in the medical service at that time. Some of the charges made against it were not true; others were the result of situations completely beyond the control of the medical service. Nevertheless, it is true that, taken as a whole and with due appreciation of bright spots here and

there, it could not be considered an entirely satisfactory medical service.

There were several reasons for this. First, any medical service, that is submerged in the subordinate position that this medical service had occupied for many years, is bound to be poor medical service. Since the very essence of good medicine is the care and treatment of patients, it is difficult to understand how anyone could expect a non-medical man, regardless of his abilities, to operate a good medical service. It is a great fallacy to say that a non-medical man can control any medical operation, leaving the actual care of patients to the doctors; because nothing goes on in a hospital, or in the medical service as a

*Delivered before the American Legion Advisory council on Medicine on February 21, 1947*



whole—utilities, supply, recreation—nothing goes on around a medical service that does not in some way affect or impinge upon the treatment of the sick.

Second, no one in the world can operate an acceptable medical service under Civil Service rules. The very foundation of the Civil Service, and its only real reason for existence, is protection of and security for the employee. The first concern of a good medical service must be the protection of the patient—not of the employee.

Under Civil Service Regulations—at least as they are interpreted by the Civil Service—it is practically impossible to employ brains. I shall give you one example. I have, at present in my office, one of the best x-ray engineers in the country. He has already saved the Government thousands of dollars in the purchase of x-ray equipment, and he has greatly improved the quality of equipment that is now being purchased. I am terribly afraid that I shall soon lose him. Why? Because the only other employee that he supervises is his own stenographer; and the Civil Service will not give him a grade commensurate with his brains, his experience or his value to the service, but only a grade which represents the number of other employees whom he directs.

Public Law No. 293 of the 79th Congress, which created the Department of Medicine and Surgery of the Veterans Administration, would be the greatest charter ever granted a medical service except for one serious defect. It did not go far enough. It goes only as far as we were able at that time to get it to go; and we believed that half a loaf was better than nothing. The success of the half loaf that we did get should convince any unprejudiced person that the whole loaf would perfect the organization.

A century or more ago, sick people were treated only by doctors. Then came the professional nurse, and the doctor-nurse team became accepted as a necessity in every case of serious illness or injury. But medicine progresses; and a few years ago the doctor-nurse team became inadequate to give to the patient everything that would contribute to his speedy recovery. In this or that illness, dietitians became essential. In this or that illness or injury, physical and occupational therapists became indispensable. And then, as medicine advanced, clinical psychologists and professional trained social workers became highly essential members of the medical team. I cannot stress to you too strongly that first class medicine can no longer be practiced

by individuals. The medical team is here to stay, and it must include all of the allied professions which can, through their own specialized training, contribute to the recovery of the patient.

The Civil Service places the same obstacles in the way of our employment of allied professional personnel as it does in the case of my x-ray engineer. Furthermore, the regulations of the Civil Service make it most difficult, if not entirely impossible, for us to give advanced training to those classes of medical personnel who remain under the Civil Service. Another thing, Civil Service personnel work a 40-hour week. The exempted personnel of the Department of Medicine and Surgery work as many hours a week as are required to give patients proper care. Do any of you think we should practice medicine by the clock?

But, entirely aside from these very practical difficulties, it is impossible to build a smoothly working, homogeneous service out of part Civil Service personnel and part exempted personnel. You cannot build a good team when a barrier is erected to separate one-half of your players from the other half. Just as no nation can exist half slave and half free, so the Department of Medicine and Surgery will never develop its full potentialities with half Civil Service and half exempted personnel.

I am informed that the American Legion will oppose any extension of Public Law No. 293 to include the other classes of professional personnel so important to the care of the sick and injured. I hope sincerely that this is not true. But if it is true, I can only ask: Is the American Legion more interested in the veteran employee than it is in the veteran patient? Because the only possible reason that any disinterested person could oppose such a step is that of protection of the employee. It is one thing to protect an employee who shuffles papers. It is another thing to make protection paramount in an employee who deals with the most precious and most perishable thing in the world . . . the life and future health of a patient.

Now that we are on this subject, I have been accused of discriminating against old employees of the Veterans Administration in distributing the benefits of Public Law No. 293. It has been said that only the newly recruited physicians have been given the higher grades. These are the figures:

When the Department of Medicine and Surgery was first organized, 56 per cent of the old Veterans

Administration physicians were given higher grades than they held under Civil Service; and, since that time, an additional 5 per cent have been promoted—making some 61 per cent of the older physicians who have been advanced in the Department of Medicine and Surgery. Four per cent were denied appointment. There you have the figures—61 per cent were promoted and 4 per cent were fired. Do you think we have been terribly unjust to the older doctors in VA?

Two years ago it was generally admitted that the standards fixed for several categories of professional personnel were too low; that these standards had not kept pace with the advances in professional education and training. I found this to be true. In my naivete, I thought that everyone wanted the standards for professional personnel elevated to those in general application in private hospitals. It never occurred to me that anyone would desire, much less insist upon, less qualified people to treat the veteran than were permitted to treat private patients in our better hospitals. So, I raised the standards; and much to my astonishment, became at once the target of complaints and abuse on the ground that I was doing a great injustice to certain old employees—the same old story—. I wonder whether anyone was ever concerned over possible injustice to the patients over the years, patients who came to the Veterans Administration expecting the best care, and entitled to the best care. It seems to be a common misimpression that, merely because a person has occupied a position for a few years, that person is eminently fitted for the position and has a vested right in it.

Now, as a matter of fact, we have not discharged any old employee merely because he or she could not meet the new standards. It is true that we have not raised unqualified employees to high positions. It takes an abler man than I to make a silk purse out of a sow's ear. But these old employees, who cannot meet present standards, have lost nothing. They are all at least as well off as they were, and some are better off. And they had little to look forward to before the advent of the Department of Medicine and Surgery.

So long as I have the responsibility of the Department of Medicine and Surgery—which I pray devoutly will not be much longer—the only individual who has a vested right in anything is the patient; and he will continue to have the right to the best in medicine so long as I have any voice in the matter.

For the first time in its history, the medical service of the Veterans Administration has the respect of the leaders of the medical profession of this country. First class medical men are the only competent judges of the quality of medical service. And, whereas first class medical men may occasionally differ in the diagnosis and treatment of a patient, they are in complete agreement upon what constitutes first class medicine. For this reason I would be perfectly willing for the National Medical Advisory Council of the American Legion to prescribe the professional standards for the Department of Medicine and Surgery of the Veterans Administration. This council would prescribe the same standards as are prescribed by my own professional services. And, in the interest of better medical care for the veteran, I hope the word "Advisory" is dropped from the title of this distinguished group, and that they determine the medical policies to be followed by the American Legion. So, what do you doctors want? Do you want the veteran to have the very best in American medicine? If so, he can have it. But he can't have it if politics and pressures are permitted to influence this service. The very moment that the rights of the employee are placed above the hard-earned rights of the veteran patient, this not only ceases to be a good medical service but becomes a medical service fit only for condemned criminals. If such a medical service is ever offered to the veteran, it will be offered by someone other than I.

The majority of the people in this room have taken the same solemn oath. I wonder how many of us remember it. It might not be amiss to repeat it. The words are somewhat archaic—echoes of a remote past—but the spirit is as modern as the atomic bomb; and so let all of us renew this oath at this time, making it apply to our professional relations with our veterans.

"I swear by Apollo the physician, by Aesculapius, Hygeia, and Panacea, and I take to witness all the gods, all the goddesses, to keep according to my ability and my judgment the following Oath:

"To consider dear to me as my parents him who taught me this art; to live in common with him and if necessary to share my goods with him; to look upon his children as my own brothers, to teach them this art if they so desire without fee or written promise; to impart to my sons and the sons of the master who taught me and the disciples who have enrolled themselves and have agreed to the rules of the profession, but to these alone, the precepts and the instruction.



I will prescribe regimen for the good of my patients according to my ability and my judgment and never do harm to anyone. To please no one will I prescribe a deadly drug, nor give advice which may cause his death. Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my act. I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by specialists in this art. In every house where I come, I will enter only for the goal of my patients, keeping myself far from all intentional ill-doing and all seduction and especially from the pleasures of love with women or with men, be they free or slaves. All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad, I will keep secret and will never reveal. If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but if I swerve from it or violate it, may the reverse be my lot.”

I would emphasize only a few passages of this oath.

“I will prescribe regimen for the good of my patients . . . and never do harm to anyone . . . . To please no one will I . . . . give advice which may cause his death.” . . . . And I pledge myself right here that, to please no one, will I knowingly consent to anything in the Department of Medicine and Surgery that will prejudice the life of any veteran, regardless of any pressure exerted.

“I will not cut for stone, even for patients in whom the disease is manifest; I will leave this operation to be performed by specialists in this art” . . . . Nor shall I ever knowingly permit a veteran to be oper-

ated upon by a doctor not specially trained for such an operation. Let's educate the laity to the fact that not all doctors are qualified to treat all kinds of patients.

“In every house in which I come, I will enter only for the good of my patients” . . . . So far as I am able to control it, no doctor, nurse or other employee will ever enter a veterans hospital for any other than the good of our patients. We shall not enter it for the money we are paid. We shall not enter it to punch a time clock and wait for the closing whistle. We shall not enter it for personal, political purposes.

“If I keep this oath faithfully, may I enjoy my life and practice my art, respected by all men and in all times; but, if I swerve from it or violate it, may the reverse be my lot” . . . . Thus far, the Department of Medicine and Surgery has kept this oath. It has enjoyed the life, and the practice of good medicine. It has gained the respect of all medical men whose good opinion we value, and the respect and affection of thousands of patients who have been given good care. It has *not* gained the respect of *all* men, because there are men whose primary interest in the Department of Medicine and Surgery is not in the good care of its patients. The respect of these men it shall perhaps never enjoy.

And, in conclusion, I am going to repeat the penalty, and renew it for myself: “If I swerve from it or violate it”—if I deviate from the course I have set or permit myself to be driven from it—“may the reverse be my lot”—may I never again enjoy my life; may I never again practice my art; may I lose the respect of all men in all times!



# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### Medicine and National Security

Dr. Edward L. Bortz in his paper on this subject has many things to say which are of deep interest to physicians. Our veteran doctors, in particular, will recognize in his remarks a determined effort to correct many of the errors of the recent war experience. The questionnaire upon which the American Medical Association is now engaged, which will include also a certain number of physicians who remained in civilian practice during the war, will be greatly helpful in securing useful information on this subject. The emphasis of the need for a unified medical corps under the direction of a council representing not only the armed services but also the fields of medical education, practice, administration, and research will be viewed as a sound approach to a part of this whole problem.

If, as seems inevitable, we are to maintain in peacetime a relatively larged armed forces, further emphasis on Military Medicine as a career is logical. The recommendation that a certain number of scholarships be offered by the Government to proficient medical students is a realistic approach to influencing medical graduates in the direction of a medical military career. The author's remarks on the Fullbright-Taft bill wherein a Department of Health, Education and Security would be set up with the head of the department to have Cabinet status is of special interest. Recently our president, Dr. James R. Miller, as a member of the Board of Trustees of the American Medical Association

pointed out to the Senate Committee on Expenditures in Executive Departments that as early as 1884 the House of Delegates recommended that an executive department of health be established with a Doctor of Medicine at its head, to supervise and direct the affairs of the federal government pertaining to health. Dr. Miller further stated that, since it is the concern of the American Medical Association that medical and hospital care be kept at the highest possible level, the grouping of health activities would provide "an opportunity to watch the coordinated development of health function in the federal government so that the Congress in its wisdom may determine the validity of our hopes for a department of health with cabinet status." Dr. Bortz's paper is not pleasant reading as it is concerned with warfare in the future. It does, however, look at certain facts squarely and in so doing gives rise to a good deal of sober thought.

### The Doctor and Health Legislation

No group in our social organism has greater reason to be aware of the rapid changes in our social structure than the medical profession. The provincial insularity which characterized the profession not so many years ago no longer can exist in a world where on some fronts medicine is fighting for its life as an independent and democratic body organized for public servcie. The time has come when medicine must make rapid progress along the road of political thinking if it expects to continue to serve the best



interests of both the public and the profession. The relation of medical societies to legislative bodies must also change, for no longer can we assume a passive role in considering measures having to do with health legislation. Instead of continuing a policy of favoring or disfavoring this or that health measure promulgated by politicians, we should be on the alert not only to foster but to introduce health measures that we know to be of public benefit. Our legislation committees should extend their purposes to seek out discrepancies in present laws and look for opportunities to establish new legislation aimed at improving health and medical care. "The practice of medicine is not merely a private pursuit, it is a social responsibility."

### Lobotomy in Connecticut

The last meeting of the Connecticut Society of Neurology and Psychiatry, held at the Fairfield State Hospital on March 20, 1947, was devoted to a discussion of prefrontal lobotomy. Dr. Burness E. Moore, assistant professor of psychiatry at the Yale University School of Medicine, gave a report summarizing the results achieved by this procedure in five psychiatric hospitals within the State. Dr. Samuel Friedman, clinical director of the Fairfield State Hospital, discussed the experience of the Fairfield State Hospital group with lobotomy patients. Dr. Jane Oltman presented several patients who demonstrated the striking benefit brought about by the operation. Dr. Bernard S. Brody, assistant clinical professor of surgery at Yale and neurosurgeon at the Fairfield State Hospital, presented a paper discussing the history of lobotomy and showed lantern slides and colored movies demonstrating the procedure.

The operation of prefrontal lobotomy for mental disorders was begun on an extensive scale at the Fairfield State Hospital in May of 1946. At the same time, plans were underway to begin the procedure at the Connecticut State Hospital, the Norwich State Hospital, and at the Institute of Human Relations at Yale, but shortage of equipment and personnel delayed the start of the program at these hospitals.

In the latter part of the summer, a meeting was held at the Connecticut State Hospital to organize a program of cooperative study and research. A Lobotomy Committee, consisting of the clinical directors of the State Hospitals, the physician-in-charge of the Yale Psychiatric Inpatient Clinic and a representative of the Institute of Living, was

formed to plan a program. Several meetings were held at which it was agreed that each hospital would provide certain common data upon all patients, and a central registry of cases was established. The report of Dr. Moore at Fairfield was a result of this co-operative project. Data are now available on 125 patients who have had the operation. The preliminary report given at Fairfield covered 110 patients who had been followed for a minimum of one month postoperative. Forty per cent of the patients were much improved, 42 per cent were improved, 11.8 per cent unimproved or worse, and 6.3 per cent had died (in only 4 instances as a result of the operation).

A more detailed analysis of 88 patients was possible, of whom 68 were schizophrenic patients, 43 sick for over 5 years and 29 hospitalized over 5 years. Fourteen of the 68 patients were much improved and 45 improved; 6 were unimproved and 3 died. This is a comparatively good result for patients of such chronic and otherwise hopeless mental illness.

Of importance in the Committee's report is the fact that there was a significant difference in the improvement of patients who had been ill and hospitalized over 5 years as compared to those sick for a shorter period of time. Although it is apparent that patients may still improve even after hospitalization for as long as 5 years, it would seem that schizophrenic patients with an unfavorable prognosis and poor response to other types of therapy should be submitted to the procedure earlier in the course of their illness in order to obtain best results.

Perhaps more important than the actual results achieved in this group of 110 patients is the promise afforded by a relatively new and aggressive form of treatment for mental conditions that have been therapeutically intractable heretofore. A hopeful sign is the evidence of cooperation between the state hospitals and private psychiatric institutions within the state in the attack upon this problem. This is a new and progressive step which may lead to mutual stimulation and fruitful results in other fields as well as lobotomy.

### The Blue Cross Needs Change

Under this title, Gordon Davis, of Michigan, public relations consultant, writes in the *Modern Hospital* for January. Mr. Davis criticizes methods of payment to hospitals, high salaries of Blue Cross directors, and "preoccupation with ornaments rather than fundamentals (which) already has led in some

instances to effort to repair the roof while the foundation has collapsed." "There was a time," he writes, "when Blue Cross executives could console themselves by saying that, bad as Blue Cross might be in some individual instances, it still was better than anything else in the field." However, regular "insurance is beginning to develop policies that offer true competition . . ." Commercial insurance companies are now writing extended coverage that includes life insurance, and health and accident compensation for subscribers, plus hospitalization and medical and surgical fees for both subscriber and his dependents. Concerning hospitals and plan relationships, Davis observes, "It should become apparent that no payment method can survive unless it is acceptable not simply to a good majority of the hospitals but *all* of them. The situation which places hospitals and plans on opposite sides of the bargaining table is an unhappy one at best." Further criticism states, "I am beginning to question whether Blue Cross plans are sufficiently sensitive to the wants of the public. Within Blue Cross there has been a certain evangelical zeal which, in at least some of its major characteristics, is indistinguishable from that of the several planners who would saddle us with compulsory governmental health insurance."

### A Trojan Horse

One of the basic principles for health centers provided for under the Hill-Burton Act was that diagnosis, treatment, and medical care of the individual is not the function of a health center but of the medical practitioner. The Division of Hospital Facilities in the Bureau of State Services of the U. S. Public Health Service was established to administer the act. V. M. Hoge, M.D., is chief of that division. In two recent articles he has presented an entirely different concept of the function of a hospital or health center. Dr. Hoge states that, "The act itself is testimony of the fact that the current conception of public health includes responsibility for the treatment and care of the individual." (*Social Security Bulletin*, October 1946, page 15). Again, "Nevertheless with this act, hospitals have been brought into and made a part of the public health structure. The act reflects the current concept that public health includes responsibility for the treatment and care of the individual." (*Hospitals*, January 1947, page 70). The *Monthly News Letter* of the American College of Radiology in commenting on Dr. Hoge's statements said recently:

"Although both of these articles were undoubtedly prepared prior to the A.M.A. meeting in Chicago in December 1946, this is not a new conception of the functions of hospitals and health centers among certain high ranking officers in the Public Health Service. It is part of the social philosophy that the state should control and direct more and more the production and distribution of goods and services. Since the depression of 1929, this philosophy has been rather widely accepted, and many of its early advocates have moved up to important positions in government agencies, particularly in the Social Security Administration, Public Health Service, Children's Bureau, and Federal Security Agency.

"The medical profession supported the Hill-Burton bill. But at the same time it was successfully defending the principle that under our political system the legitimate function of government did not extend to the control of medical practice. The Hospital Survey and Construction Act was represented as being just that; for a survey of construction needs and grants-in-aid to assist states to construct hospitals where need was demonstrated. In supporting a bill to provide funds through taxation for constructing facilities in which physicians could more effectively serve the sick, the medical profession did not concede that public health agencies or hospitals should take over any part of the practice of medicine.

"It would be unfortunate indeed if Dr. Hoge's philosophy were to prevail in the administration of Public Law 725. His concepts are as alien to the philosophy of a free democratic society as those expressed in the Wagner-Murray-Dingell bill. Nothing in the act itself justifies the statement that it endows public health agencies or hospitals with any responsibility for the treatment and care of the individual. Certainly this was not the intent of Congress in enacting it.

"Fortunately, administrative policies under the act will be determined on the state level. It is the responsibility of state medical societies to see that the Hill-Burton act does not become a Trojan horse."

### General Hawley at His Best

Elsewhere in this issue may be found Paul R. Hawley's address at the recent conference of Medical Advisors of the American Legion. Sitting before him that evening one was impressed by the fact that never before had the Chief Medical Director of the Veterans Administration appeared so forceful, so



determined that the veteran should have the best medicine has to give, so bent on reaching the heights of medical practice. It was a masterly presentation and all the more so since it left no loophole for the advocates of partisan politics or the civil service aspirants to seats among the mighty.

The medical profession needs no argument to convince its members of the successes which have followed General Hawley's program for the Department of Medicine and Surgery of the Veterans Administration. His imperviousness to political onslaughts has been an outstanding trait. His high standards of medical care and his program for medical education of his personnel have won him admiration and respect. His fairness and squareness have made him many friends. As long as Paul Hawley continues to administer the medical branch of General Bradley's rebuilt Veterans Administration the American people may rest assured the job will be done as near perfectly as it can be. Our only fear is that some day before the last sick veteran has been cared for Dr. Hawley may find it necessary to lay down the task for another to finish.

### Hello to the Gram

The editorial *Goodbye to the Grain*, published on page 485 of the December *Journal of the Medical Society of New Jersey*, has called forth comment from E. Fullerton Cook, chairman of the Committee on Revision of the Pharmacopoeia of the United States. Mr. Cook makes the following remarks:

"I appreciate your feeling about losing an old friend, but I am convinced that those who have grown up with the 'grain' and are really willing to try to learn and use the metric system will soon find it a great advantage.

"Those who think metrically will prescribe 5 cc. (not 4 cc.) for the condition calling for 'about a teaspoonful dose,' and then their calculations for the 100 cc. prescription will be easy and they will see that they have twenty doses or enough medicine, three times a day, for a week (less one dose).

"When one thinks of 4 cc. as the dose, one is being influenced by the old system and the thought of a drachm and a teaspoonful as being the same. We should forget the drachm. As a matter of fact, the modern teaspoon, available in a home, is much more likely to be 5 cc. than 4 cc.

"I hope that you will help establish the metric dose and not discourage it. At best it will take years to make it universal. I believe it was Osler who said that most men after 40 won't learn."

### Medical Expense Cover

(Editorial Comment—*The National Underwriter*,  
February 13, 1947)

All of this merry-go-round discussion of medical expense insurance causes us to wonder whether the idea isn't something of a mare's nest. When hospital insurance was launched, it caught hold immediately. There was a natural appetite for it and it swept the country. Surgical insurance as an adjunct of hospital cover has been immensely popularized. We are inclined to bracket medical expense insurance with these other two lines, but perhaps that may be a mistake. It may be a horse of an entirely different garage.

So far as we can observe there is no great popular demand for medical expense protection. Where it has been offered on an individual basis its sale has been scattered even with a lot of publicity buildup. The idea is splitting the doctors into rival camps and is precipitating angry wrangling over ideology in the realm of medical economics.

Our guess is that if the threat of socialized medicine or of a federal medical expense insurance scheme should disappear, the doctors would relax and the private insurance companies would cease trying to devise some way of providing the cover on an individual basis. The doctors are primarily interested in insurance of this kind as a means of heading off a federal plan and the insurance companies are trying to go along with the doctors.

In the usual sickness, the doctor's bill for other than surgery is the least of the patient's worry. It is the hospital, nurse and cost of surgery that hits him amidships and causes him to dip into his savings or go to a personal loan company for aid. The doctor's bill is something that usually can be taken pretty much in stride and arrangements can usually be made to pay it in installments.

We believe that the average person realizes this difference and is not demanding medical expense insurance nor is he particularly attracted to it when it is made available.

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### Safety Devices in Mines

More than 100 different safety devices, machines and methods have been introduced into American mines in the past twenty years at a cost exceeding \$100,000,000—reducing accidents by half, or at a rate averaging 4 per cent per year on a basis of production.



## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN



Left to Right, Front Row: Thomas A. Hendrick, chairman, A.M.A. Council on Medical Service; Grace Mooney, assistant executive secretary; James R. Miller, president-elect; Cole B. Gibson, president; John E. Farrell, executive secretary, Rhode Island Medical Society; Hugh B. Campbell, treasurer

Back Row: D. C. Y. Moore, councilor, Hartford County; Herbert Thoms, councilor, New Haven County; Aruthur B. Landry, Hartford County member on Committee to Study Organization and Objectives of the State Society; Creighton Barker, executive secretary; Floyd A. Weed, councilor, Litchfield County; Joseph H. Howard, delegate to A.M.A.; Charles T. LaMoure, councilor, Tolland County

### COUNTY PRESIDENTS - SECRETARIES CONFERENCE

Warning that "annual meetings are not going to be enough" and that the future trend of medicine can be influenced by medical organizations only through closer coordination of county, state, and national activities, Thomas A. Hendricks, secretary of the A.M.A. Council on Medical Service and Public Relations, addressed the Semi-Annual Conference of County Presidents and Secretaries Thursday afternoon, March 20, at the residency of the New Haven Medical Association.

The speaker emphasized that the principal aims of medical groups should continue to be the devel-

opment of the best possible medical care for all of the people at the lowest possible cost.

"We are going to need more effective organization and more concentrated efforts" the Council secretary declared, and cited the continuing political agitation in health matters as an impelling force which cannot be ignored if the ideals of medicine are to survive.

He pointed out that the Taft-Fullbright bill, while it eliminates undesirable features of political control contained in previous Wagner-Murray-Dingell measures, "places full responsibility on each medical



society and on individual physicians." Its passage would require almost immediate assumption of responsibilities for the national health by voluntary medical organizations, he said, and cautioned that such responsibilities could be discharged only through fully effective organization.

Speaking on "The Purposes of a State Medical Journal," John E. Farrell, executive secretary of the Rhode Island Medical Society, told conference members that "editorials are the backbone of our state medical journals," and that vigorous editorial policies can contribute to the good repute of the medical profession.

"If editorials are the heart of a publication, then it should certainly beat louder than it does in our state medical journals," he declared.

He said that the *Rhode Island Medical Journal* recently adopted a militant editorial policy to answer attacks against the medical profession, and that this has attracted wide public response and favorable reaction.

Among other needs of most medical journals he included the publication of more news from county and city medical groups, increased interest on the part of physicians to prepare clinical papers for publication in their journals, and the use of material on health matters prepared by lay groups. He commended the CONNECTICUT STATE MEDICAL JOURNAL for its progressive policies.

Cole B. Gibson, president of the State Medical Society, presided at the conference, following a welcoming address in which he forecast increasing importance for these joint meetings of county and state organization officers.

In a discussion following addresses by the guest speakers, James R. Miller, president-elect of the Society, and member of the A.M.A. Board of Trustees, spoke briefly concerning the importance of closer relationships between individual physicians and their medical organizations.

Declaring his belief that "New England conservatism isn't always a good thing for the Medical Society," D. C. Y. Moore, councilor from Hartford County, urged that county associations aid their secretaries by parttime employment of responsible individuals as administrative assistants.

Herbert Thoms, councilor, and literary editor of the State Medical JOURNAL, outlined the program recently undertaken by the New Haven County Medical Association to increase the effectiveness of

its organizational activities.

In a panel discussion concerning the administrative activities of the state and county organizations, Creighton Barker, state executive secretary, emphasized the importance of maintaining up-to-date records of membership. He urged county secretaries to notify the state office as early as possible regarding membership changes.

The system of membership records in use in the state office was demonstrated by Mrs. Barbara Lipton, and dues and collections were discussed by Hugh B. Campbell, treasurer.

Following dinner at 7:00 P. M. the status of the Society's program for prepaid medical service was outlined by Dr. Miller, chairman of the committee now developing the plan with insurance carriers. He told the conference that the plan has been progressing favorably, and that its provision for cash indemnity rather than guarantee of full medical service was considered, after long study by the committee, as the only sound approach to the problems involved.

Attendance at the conference included the presidents of the Hartford, Litchfield, Middlesex, and Tolland County Medical Associations, and secretaries from the counties of Fairfield, Hartford, Litchfield, and New London. All members of the council were present except two who were unable to attend because of illness.

The conference adjourned at 10:30 P. M.

### April Council Meeting

The Council held its regular monthly meeting on April 11 at the office of the Society. The meeting was called to order at 4:30 P. M. by the chairman, Dr. Murdock. There were present, in addition to Dr. Murdock, Drs. Miller, Howard, Campbell, Weld, Thoms, Weed, Gildersleeve, Gibson, Barker, and Phillips. Also, Dr. Berkeley M. Parmelee, newly elected Councilor from Fairfield County, replacing Dr. Samuel F. Mullins, resigned. Also, Miss Mooney and Mr. Burch. Absent: Drs. LaMoure, Moore and Speight.

The chairman of the Council had invited Dr. Courtney C. Bishop, New Haven, and Dr. Oliver L. Stringfield, Stamford, to meet with the Council at this time. Dr. Bishop is the chairman of the Committee to Study the Organization and Objectives of the Society and Dr. Stringfield is a member of that Committee.

## COMMITTEE ON INDUSTRIAL HEALTH

The secretary reported that Dr. Gerald M. Charter, Danielson, and Dr. George C. Fawcett, South Norwalk, had expressed a desire not to be re-nominated to the Committee on Industrial Health.

## COMMITTEE ON HEALTH AND PHYSICAL EDUCATION

An informal report from the Committee on Health and Physical Education was presented from Dr. Joseph L. Hetzel, chairman of the Committee. It was agreed that this Committee should be continued for another year as nominated and that the secretary should communicate with Dr. Hetzel relative to the possibility of interesting the Woman's Auxiliary of the Society in the Committee's projects.

## PUBLIC RELATIONS

A request for approval of a publicity project in the form of a health column for newspapers was presented from the Committee on Public Health. The proposal was explained at length by Mr. Burch who had conferred with the Committee and it was finally agreed that Mr. Burch should ask for a meeting of the Society's Committee on Public Relations for further consideration and planning and that the editor of the JOURNAL and the secretary of the Society would be asked to meet in this conference, and, further, that the Committee on Public Relations be asked to submit a definite proposal to the Council at its next meeting.

## DR. GIBSON ON BOARD OF TRUSTEES OF THE BUILDING FUND

At the request of the Board of Trustees of the Building Fund, Dr. Cole B. Gibson was appointed a

member of that Board to complete the unexpired term of Dr. Daniel Sullivan who has resigned.

## COMMITTEE TO STUDY WORKMEN'S COMPENSATION LAWS

Dr. C. Louis Fincke, Stamford, was named a member of the Society's Special Committee to Study Workmen's Compensation Laws, replacing Dr. Addison H. Bissell, Stamford. Dr. Thomas Soltz, New London, was designated as chairman of the Committee.

## ADVISORY COMMITTEE FOR VETERANS PLACEMENT SERVICE

A request was presented from the Veterans Placement Service Board of the Veterans Employment Service asking that the Society provide a medical advisory committee to the Board. It was agreed to ask Drs. Bliss B. Clark, New Britain; Cecil R. Garcin, Danielson; Robert V. Nespor, Westport; Charles I. Solomon, Meriden; and Arthur C. Unsworth, Hartford to serve on this Committee, and that the Veterans Employment Service be requested to ask these members of the Society to serve on its Advisory Committee.

## DR. WELLS ON SPECIAL COMMITTEE TO STUDY MATERNAL MORTALITY AND MORBIDITY

Dr. Elizabeth C. Wells, Hartford, was appointed as an additional member of the Society's Special Committee to Study Maternal Mortality and Morbidity at the suggestion of Dr. Joseph H. Howard, chairman of the Committee.

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## THESE GAVE

### CONTRIBUTORS TO THE BUILDING FUND — MARCH 10 TO APRIL 10

## FAIRFIELD COUNTY

Rockwell, A. E., Bridgeport  
Weber, F. C., Jr., Greenwich

## HARTFORD COUNTY

Antupit, L., Hartford  
Baskin, A. H., Hartford

HARTFORD COUNTY—*Continued*

Ellison, F. S., Hartford  
Grau, L. C., Hartford  
Slyz, L. B., New Britain  
Valenski, T. J., Thompsonville  
Weisenfeld, N., Hartford  
Whittles, L. J., Glastonbury

## NEW HAVEN COUNTY

Blumenthal, E. J., Ansonia  
Casagrande, J. J., Ansonia  
Haddad, F. M., Ansonia

## NEW LONDON COUNTY

Bergendahl, H. A., Norwich



## Dr. Miller Represents A.M.A. on Joint Committee

Dr. James R. Miller, of Hartford, who recently assumed office as president of the Connecticut State Medical Society, has been chosen to represent the American Medical Association on a joint committee with the American Public Welfare Association to devise principles of improving medical care for the chronically ill. A member of the A.M.A. Board of Trustees, Dr. Miller is also chairman of the National Service Committee of the American Cancer Society.

## Pediatricians Honor Dr. Paul S. Harper

Paul S. Harper, M.D., of Fairfield received the Mead Johnson pediatric award at the annual meeting of the Academy of Pediatrics in William Penn Hotel, Pittsburgh. The award which is given annually in recognition of outstanding contribution to pediatrics, was presented specifically for work on "malaria and other insect-borne diseases in the South Pacific." Dr. Harper's paper reviewed briefly the importance of insect-borne diseases to a military force in the tropics and described the joint Army-Navy organization which was developed in the South Pacific area to control the diseases.

## New City Dispensary Resident Physician in Bridgeport

Leonard C. Veneruso, M.D., of Bridgeport, has been appointed resident physician in charge of the medical, surgical, prenatal and pediatric clinics in the City dispensary, it was announced recently by Dr. James Douglas Gold, president of the board of governors of the City dispensary. Formerly a flight surgeon with the Army Air Forces, Dr. Veneruso succeeds Dr. Andrew P. Owens of 385 Noble Avenue who has resigned.

## Greenwich X-ray Project

The community x-ray project conducted by the Greenwich Tuberculosis and Health Association and the Greenwich Health Department on October 30, 31 and November 1 and 2, 1946, resulted in 1,592 persons being x-rayed. Those who were x-rayed came from every section of Greenwich, making it truly a community project. The cooperation of many agencies, business organizations, and individuals was responsible for the large number who took advantage of the opportunity to be x-rayed.

## Dr. Gillson Addresses Pharmacists

Trends in skin preparations were discussed recently at the monthly meeting of the Connecticut Association for the Advancement of Professional Pharmacy in New Haven. Principal speakers were Reginald E. Gillson, M.D., prominent New Haven dermatologist, and John Zugich, chief pharmacist at the New Haven Unit, Grace-New Haven Community Hospital.

Dr. Gillson, who specialized in dermatology and allergy at the New York Postgraduate Hospital, pointed out that no two patients can be treated alike when it comes to skin infections. Despite the great advances made in the field of dermatology, he said, the proper selection of ointments and cream base preparations is essential for good results.

Mr. Zugich, who established the pharmacy section of the Oak Ridge, Tenn., hospital during the war, continued the discussion with demonstrations of some of the newer pharmaceutical advances in combatting skin infections. Among these were various soap substitutes, the use of penicillin as a "dusting powder" for infections in babies, DDT as a treatment for vermin infections and the use of pectin, a fruit derivative, in the preparation of ointments and lotions.

Mr. John DeNicola, president of the society, presided at the meeting. Mr. John J. Dugan, program chairman, commented on current research on streptomycin as a treatment in certain skin infections that have failed to respond to penicillin. Mr. Dugan also demonstrated the usage of new soap substitutes available for personal and household use.

## Seven Nations Have Ratified WHO Constitution

Seven nations have ratified the Constitution of the World Health Organization, according to a report from the WHO Interim Commission. Two of the seven nations—China and the United Kingdom—became parties to the Constitution by signature without reservation when the instrument was established July 22, 1946.

Other nations to ratify include the following in order of their approvals: Canada, Iran, New Zealand, Syria, and Liberia.

Under the terms of the Constitution 26 members of the United Nations must ratify the instrument before it comes into force, and the WHO becomes a specialized agency of the United Nations.

## CENTRAL MEDICAL ASSOCIATION CELEBRATES CENTENNIAL

The Central Medical Association, observing its centennial on April 9 at the Griswold House, Essex, presented a gold pen and pencil set to Dr. James Murphy of Middletown in honor of his fifty-two years in the practice of medicine. Dr. Murphy has been a member of the Association over fifty years and in his fascinating review of the past one hundred years was able to relate many personal reminiscences and stories of some of the early members. He was also a speaker at the sixtieth anniversary in 1907 when he prophesied future events and is one of three members now alive who were present on that occasion.

The principal speaker was Dr. Morris Fishbein, editor of the *Journal of the American Medical Association*. He discussed The Motivation of the American Medical Association. Speaking with his usual rapidity for nearly an hour, Dr. Fishbein held the undivided attention of the one hundred thirty physicians and wives present. Dr. Fishbein presented a wealth of historical and economic facts and practical ideas. He praised the so-called Connecticut Plan for prepaid medical care now in the process of

development by the State Society Committee together with insurance company officials. He described the plan as the soundest advanced to date in the nation because of its democratic composition. According to Dr. Fishbein this plan separates the two problems involved, leaving the business of writing insurance to the insurance companies and the medical care program to the physicians.

Cole B. Gibson, president of the State Society, Thomas P. Murdock, chairman of the Council, James R. Miller, trustee of the American Medical Association, and Creighton Barker, secretary of the State Society, all spoke briefly. The Middlesex County Medical Association held its annual meeting in conjunction with the Central Medical Association. It was a gala celebration and will be long remembered by those present. An interesting feature of the program was the printing of excerpts from the old records of the Association, together with the menu of the dinner, a list of active members at the sixtieth anniversary, and the names of all the officers since the founding in 1847.

## AMERICAN COLLEGE OF SURGEONS SECTIONAL MEETING IN PROVIDENCE

THE Section Meeting of the American College of Surgeons was held at the Providence-Biltmore Hotel, Providence, Rhode Island, on March 28 and 29. There were approximately 500 doctors present from Maine, New Hampshire, Vermont, Massachusetts, Rhode Island, Connecticut, and a few from New York City. The program each day was opened by a series of medical motion pictures. The first day these included reels on (1) Transthoracic Total Gastrectomy with Intrathoracic Esophago-Jejunal Anastomosis for Carcinoma of the Stomach; (2) Support of the Paralyzed Face with Fascia; and (3) Use of the Gelatin Sponge for Control of Hemorrhage. All procedures were well illustrated. In the second reel the efficacy of the use of fascia removed from the thigh to support a paralyzed face in which nerve sutures had failed was ably demonstrated. Dr. Hilgar P. Jenkins showed in the third reel how gelatin sponges could be used in large openings of the aorta, heart and vena cava, with complete con-

trol of hemorrhage from pressure in about three minutes. The histological and pathological results of animal experimentation were demonstrated and their application to clinical cases.

The moving pictures the second morning were on (1) Bilateral Femoral Vein Interruption for the Treatment of Deep Venous Thrombosis and Pulmonary Embolism; (2) Pancreato-Duodenal Resection for Carcinoma of the Head of the Pancreas or Carcinoma of the Ampulla of Vater; (3) Colectomy for Ulcerative Colitis; (4) Vagus Nerve Resection for Peptic Ulcer; and (5) Peritoneoscopy—An Adjunct in the Diagnosis of Intra-abdominal Pathology. The last picture was an unusually good one, showing the anatomical lesions seen through a peritoneoscope.

Each day at 10 o'clock the movies were followed by the presentation of scientific papers. The first day the presiding officer was Herman C. Pitts of Providence, consulting surgeon, gynecological department, Rhode Island Hospital, and the first paper



was given by Ernest M. Daland, chief of staff at Pondville Hospital, Boston. He discussed the Treatment of Lymph-node Metastasis in the Neck and pointed out that the most important feature about lymph-node metastasis is that it should never be done at the same time that the primary lesion is removed. The primary lesion should be removed first and after the wound is healed and there is evidence that there is no widespread metastasis but that the lymph nodes involved are on the same side in which the original lesion was present, then the lymph nodes should be removed. This should be done by either the partial neck dissection or a complete neck dissection. He showed the type of incision, using a transverse incision from the back of ear to the chin in the upper neck dissection and then making a "T" in the middle of this previously described incision for the carrying out of a radical neck dissection. He pointed out that surgery in his hands gave much better results than either x-ray or radium. He thinks the second choice is the use of radon seeds, using at least 18 to 20 seeds.

The next paper was given by Ralph M. Tovell, chief of the department of anesthesia, Hartford Hospital, and lecturer in anesthesia, Yale University School of Medicine. He gave an excellent review of the Progress in Anesthesiology, mentioning the use of intratracheal anesthesia, brachiocephalic block, the use of curare in the relaxation of the abdominal wall, and the use of intravenous novocaine which he states is in its infancy, although a number have used it quite successfully in arrhythmias of the heart, both before operation and as a result of cyclopropane anesthesia.

The third paper was on the Late Results of Uretero-enterostomy by George G. Smith of the Massachusetts General Hospital who gave his experiences in the use of uretero-enterostomies, both in carcinomas of the bladder and in exstrophy of the bladder. He stated that although he had had a considerable number of successes with this implantation, in either one or two stages, of the ureter into the large bowel, in practically all instances there was evidence both by the NPN and at autopsy that there was considerable infection or pyelonephritis of the kidneys. The final answer in the transplantation of ureters into the intestines has not yet been obtained. He has used the technique of Coffey, both Coffey I and Coffey II, with his own variations but still has not found the most suitable type.

The next paper was one given by Harris B. Shu-

macher, Jr., associate professor of surgery, Yale University, whose topic was Causalgia with Particular Reference to Associated Vasomotor Changes and to Treatment by Sympathetic Interruption. He pointed out that in practically all instances of causalgia success was obtained either by paravertebral block or by the complete interruption of the sympathetic chain and removal of the lumbar sympathectomy, lumbar nerves, in the lower extremities and the removal of the dorsal ganglia for the arms. His results were extraordinary for this type of disease.

A round table discussion of the morning papers was held at the noon luncheon, questions being submitted in writing and answered by the speakers of the morning.

In the afternoon the first moderator was Robert M. Yergason of Hartford, and the collaborators were Henry McCusker of Providence, Alexander T. Aitken of Boston, and Otto J. Hermann of Boston. Their discussion dealt chiefly with the methods of treating fractures of the elbow with metal plates and other types of fixations with their results.

After this symposium was given, there was another on Intestinal Obstruction with Arthur W. Allen as the moderator and the collaborators were Clarence E. Bird of Providence, Leland S. McKitt-trick of Boston, and Robert R. Baldrige of Providence. There was nothing new in this symposium but the material was well presented and indicated the importance of the history and physical examinations and the use of x-rays in making the diagnosis. Dr. McKitt-trick pointed out also that, in addition to the fact that x-rays are helpful, they are sometimes misleading but confirmation can be made with a small amount of barium introduced into the rectum, using this as a procedure merely to outline the colon, not as a diagnostic procedure to outline the lesion. They also discussed the advent and use of sulfathiazine and sulfasuxadine and more particularly, a streptomycin in the sterilization of the large intestines.

Following a dinner in the evening for the surgeons, physicians, and hospital representatives Arthur W. Allen of Boston, chief of the East Surgical Service of the Massachusetts General Hospital and the president-elect of the American College, presided and pointed out the important role that the American College of Surgeons has played in the developing of standards of hospitals and also in helping to round out the graduate training in surgery. He stated that the College was accepting surgeons

now only with seven years training, after they had had their basic surgical training, and that they were cooperating with the American Board of Surgery. It was stated that the requirements for the American Board of Surgery have been reduced to four years as compared with the previous five years of surgical training. Dr. MacEachern of Chicago, told of the excellent work that is being done relative to the program of motion pictures and that the Johnson office was contributing approximately \$20,000 for the filming of an educational picture including the anatomy, physiology, and pathology of large organs, and demonstrating the anomalies and operative procedures. A preview showing of the anomalies of the bile ducts and blood vessels and strictures of the common duct was shown; it was a beautiful moving picture, done by Warren H. Cole, M.D., of Chicago, professor of surgery and head of the department, University of Illinois Medical College. This was not the final showing as Dr. MacEachern had pointed out that this would pass through a board of reviewers and, after the board had passed upon it, the picture would be published. They expect to produce a number of these films throughout the year and have a permanent record and department of the best motion pictures for medical education.

In addition to this, Frank E. Adair of New York, associate professor of clinical surgery, Cornell University Medical College and attending surgeon, Memorial Hospital, discussed the Cancer Detection Centers throughout the country, stating that there were 740 detection centers throughout the country, but that New York which he is most familiar with had a waiting list of females for twelve months and approximately seven months for the males. The Cancer Detection Clinics in New York operate three times a week for the females and twice a week for the males. He pointed out that these detection clinics were to work parallel with the tumor clinics; they were to have a separate staff, however. He mentioned that people were not only willing but eager to go to the clinics and that as soon as the diagnosis was established, the patients were sent back to their family physicians. All these cases consisted of a complete physical examination, a routine chest film, a Papanicalaou stain and a complete blood count and urine examination, the total cost being approximately \$7.50 for semi-private patients and a smaller charge for ward patients, and a follow-up charge of approximately \$3 or \$5.

On the second morning James W. Jameson, con-

sulting surgeon to the Concord (N. H.) Hospital, presided. Frank L. Meleney, associate professor of clinical surgery at Columbia, gave the first paper on The Use of Antibiotics in Surgical Practice. He told of the advantages of penicillin as contrasted to the sulfa drug, inasmuch as penicillin was a less toxic agent. It was effective both against staphylococci and streptococci. He pointed out that it was very effective to inject the penicillin directly into the infected areas, particularly when there was cellulitis and also that it was very effective in osteomyelitis and the earlier given, the better results. He mentioned that bacitracin is a newly found antibiotic which is good for penicillin resistant strains and in the very near future will be available for clinical use. He has worked with it experimentally and found it to be very efficacious and quite innocuous. He also pointed out the advantages of using streptomycin in the colon bacilli group and that it is particularly efficacious in the treatment of carcinoma of the colon when preparing the colon for operation.

The next paper was an excellent conservative presentation by Francis D. Moore on the Surgical Treatment of Peptic Ulcer. He gave a straightforward, honest opinion as to the advantages and disadvantages of removing the vagi. He pointed out the advantages of approaching the vagus nerve through the chest, the mortality being practically nil and the results excellent with only two immediate posterior gastroenterostomies and the remainder of the cases, (67), treated without any untoward effect. He told us that one must be very conservative in the management of these cases postoperatively and that they should be treated very gingerly with Wagensteen tubes for four or five days and put on a bland diet with frequent feedings for approximately five to six months.

There was also a paper on the Surgical Treatment of Portal Hypertension by Arthur H. Blakemore of New York who discussed the contra-indications and indications for the operation portocavoanastomosis or anastomosis of the splenic vein to the renal vein. He pointed out that it is important in all these cases of portal hypertension to have a normal prothrombin and a normally functioning liver.

Then Frank E. Adair of New York gave a paper on the Present Status of Hormones in the Treatment of Malignancy with Special Reference to the Breast. He pointed out the tremendous strides that have been made and the rapid epithelialization of the skin in carcinomas of the breast, which are inoperable, in



patients over sixty years of age treated with stilbesterol. He also mentioned that patients under sixty years of age should never be treated with stilbesterol but should be treated with testosterone. The results with the patients over sixty years of age were very good and compared favorably with the results of Dr. Nathanson in Boston who showed the same type of results in inoperable cancers of the breasts with ulcerations of the skin and lymph nodes and bone metastases with the use of stilbesterol. This substance caused a marked improvement in the calcification of the bones which were fractured as the result of metastases and also a rapid epithelialization of the skin over the ulcerated areas.

Following a round table discussion at luncheon of the subjects of the morning, there were two panel discussions, the first being on Post-operative Care with John H. Mulholland as moderator and Charles C. Lund of Boston presiding. The collaborators were James B. Blodgett of Boston who pointed out the fact that early ambulation caused no significant lowering of the incidents of pulmonary emboli and no increase in the number of hernia following early ambulation. The patients were all gotten up out of bed twenty-four hours after operation. He now advocates that the patient get up even earlier, almost immediately after operation, and also that they be given shoes and walk around. Then Bliss B. Clark of New Britain discussed the electrolytic balance of patients postoperatively as did John H. Mulholland of New York, professor of surgery, New York University of Medicine. E. A. Rovenstine then pointed out the part an anesthetist can play in the postoperative care and management in patients before and after going to surgery.

The last paper that afternoon was on Carcinoma of the Colon with Frank H. Lahey presiding, and the collaborators were Arthur W. Allen, Richard B. Cattell and Leland S. McKittrick. These surgeons reported a long series of cases of carcinoma of the colon treated with primary resection and immediate anastomosis by Dr. Allen. This procedure was made possible by the preoperative treatment which consists chiefly in treating the patient for a period of one week to ten days before operating upon him and also in the use of antibiotics, particularly sulfathiazine and streptomycin. Dr. Cattell showed that, although they are operating upon a great number of patients, they are still seeing them rather late and he hopes that the patients will be seen earlier, have earlier sigmoidoscopies done so that polyps can be

removed while still in the benign stage, rather than waiting for the development of cancer as a result of the precursor of cancer, namely, polyps.

The smaller sectional meetings of the American College of Surgeons apparently are being well received and well attended by the surgeons in each geographical area.

Peripateticus

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### Boston University Dean to Succeed Dr. Johnson as Head of Council

The Board of Trustees of the American Medical Association announced today the appointment of Donald G. Anderson, M.D., dean of the Boston University School of Medicine, as secretary of the Council on Medical Education and Hospitals of the American Medical Association.

Dr. Anderson, who will take up his new duties about July 1, succeeds Victor Johnson, M.D., who recently was appointed director of the Mayo Foundation for Medical Education, Rochester, Minn. Dr. Johnson has been secretary of the council since 1943.

Dr. Anderson is a graduate of Harvard College and received his M.D. degree from Columbia. He has had hospital and academic appointments at Boston City Hospital, Presbyterian Hospital in New York, Evans Memorial and Massachusetts Memorial Hospitals in Boston and Columbia. During the war he was associated with Dr. Chester Keefer in penicillin research for the Office of Scientific Research and Development. His research publications deal primarily with the employment of the sulfa drugs, penicillin and streptomycin in the chemotherapy of infections.

Dr. Anderson will be the executive officer of the oldest standing committee of the American Medical Association. The Council on Medical Education and Hospitals, established in 1905, was responsible for the revolutionary improvements in medical education which occurred in the second decade of this century, and is today concerned with the maintenance of high educational standards in medical schools, hospital internships and training of physicians to become specialists, as well as in such fields related to medicine as clinical laboratory and x-ray technology, physical therapy and occupational therapy.

## *Doctor---*

### INFORM YOUR PATIENTS!

Remember, the individual physicians' relations with patients are the sum total of medicine's public relations! Do your share of public relations work to protect FREE ENTERPRISE IN AMERICAN MEDICINE. Tell your patients what FREE ENTERPRISE has accomplished in American medicine and what it will accomplish if left unfettered by socialized political medicine.

#### TEN-POINT HEALTH PROGRAM\*

EXTENSION OF VOLUNTARY PREPAID MEDICAL AND HOSPITAL CARE PLANS. *People have the right to use their individual initiative to provide against the catastrophe of sickness!*

ADEQUATE MEDICAL AND HOSPITAL CARE FOR VETERANS. *The Veterans Administration and the physicians are working together in many states, including Connecticut!*

PROPER DEVELOPMENT OF NATIONAL PHILANTHROPIC HEALTH AGENCIES. *These bodies are a natural outgrowth of free enterprise and democracy!*

HIGH STANDARD OF LIVING, with adequate nutrition, housing, clothing, and recreation. *Good living conditions are fundamental to good health!*

PREVENTIVE MEDICAL SERVICES, by well-staffed health departments. *An ounce of prevention is worth a pound of cure!*

ADEQUATE MATERNITY CARE, with state or federal aid if necessary. *Connecticut has the lowest maternal death rate in the world!*

ADEQUATE INFANT AND CHILD CARE. *Every child should have proper attention throughout infancy!*

HEALTH AND DIAGNOSTIC CENTERS AND HOSPITALS. *Such facilities should be developed according to community needs!*

RESEARCH IN THE MEDICAL SCIENCES. *We endorse all efforts toward a better understanding of sickness!*

WIDESPREAD HEALTH EDUCATION. *The people must know about the prevention of disease and its treatment.*

WE CONNECTICUT PHYSICIANS BELIEVE THAT THE FINE MEDICAL SERVICE IN THIS COUNTRY HAS RESULTED FROM FREE ENTERPRISE IN AMERICAN MEDICINE. AND WE BELIEVE THAT FREE ENTERPRISE ALONE PROMISES FURTHER PROGRESS.

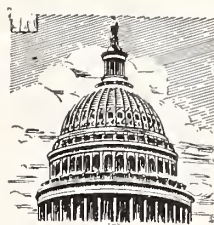
\*Adopted February 16, 1946 by the Trustees and the Council on Medical Service of the American Medical Association



## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*Fairfield County*, Charles H. Sprague, Bridgeport  
*Hartford County*, Benjamin B. Robbins, Bristol  
*Litchfield County*, W. Bradford Walker, Cornwall  
*Middlesex County*, Frank H. Couch, Cromwell  
*New London County*, Edmund L. Douglass, *Chairman*  
 Groton

*New Haven County*, Charles T. Flynn, New Haven  
*Tolland County*, John E. Flaherty, Rockville  
*Windham County*, Brae Rafferty, Willimantic

PUBLIC  
AFFAIRS

## NEWS FROM WASHINGTON

## Hearings on S140 and S712

Dr. James R. Miller, a member of the Board of Trustees of the American Medical Association, testified that while the sentiments of the members of the A.M.A. have not been passed on S140 or toward the assembling of the functions of health, education and security into one department of cabinet rank, an examination of the minutes of the House of Delegates of the A.M.A. indicates that considerable thought has been given to the formulation of a separate federal health agency. Repeatedly the minutes, as early as 1884, recommend that an executive department of health be established with a Doctor of Medicine at its head, to supervise and direct the affairs of the federal government pertaining to health. Statements that a physician competent to manage such a department or bureau cannot be found, cannot be accepted. There are among physicians, men with broad administrative experience and vision of health needs whose lives are devoted to cooperation with agencies and to the welfare of the people.

Since it is the concern of the American Medical Association that medical and hospital care be kept at the highest possible level, the grouping of health activities as in S545 will provide "an opportunity to watch the coordinated development of health functions in the federal government so that the Congress in its wisdom may determine the validity of our hopes for a department of health with cabinet status."

Dr. R. L. Sensenich, chairman of the Board of Trustees of the A.M.A., reiterated the position often taken by the A.M.A. in recommending that all health activities now existing in the federal govern-

ment be consolidated into a single department with a Doctor of Medicine at its head to supervise and direct the affairs of the federal government pertaining to the health of the people.

In the Association's devotion to improving standards of quality of medical service and to broadening the distribution of medical care to all people, constant contact with health agencies has been maintained and full cooperation with the scope of policies has been agreed upon.

Since public health is the first problem of State, the Board of Trustees opines "that health activities of the government, except those concerned with military establishment, should not be subservient to any other departmental interests." Reorganization and consolidation of health activities need not involve the expansion or extension of health activities but eliminates existing duplication.

He challenged the Federal Security Agency's argument for grouping education, health and security that "because each such agency was set up to serve a particular sphere of interest, no one of them is prepared to serve the citizen . . . as an individual human being. No one of them has a mandate to promote the basic concept of general welfare." He cited that "such an argument fails when it must be admitted by the Federal Security Agency that the implication of effective broad general contact with major portions of the population throughout the years is not well founded." The heads of the division of education must no doubt recognize that they have little control over education. Educational rehabilitation federally supported applies only to a small special group carried on through State agencies. Social security and welfare apply only to special

groups and have no universal contacts.

Important to health progress is uncontrolled productive research. "Sufficient funds alone do not attract the brilliant research mind or insure effective research." Evidence of contribution to progress in medical research by welfare, education and security, as established under FSA is not manifest. "Medical achievements in the improvement of health" are highly specialized and cannot be confined to welfare and economic security "without loss of important factors in their continuing progress."

Dr. Reginald F. Atwater, executive secretary, American Public Health Association, supported the idea of cabinet status for the Federal Security Agency as provided for by the Aiken bill (S712). The APHA opposed the Taft (S140) because it would not provide flexibility of administration but would tend to separate the functions of health, education and security rather than to promote cooperation.

Dr. Vlado A. Getting, representing the Association of State and Territorial Health Officers, testified that the Association has worked for many years for the integration into a single department of all the health activities of the federal government. "The Association," he said, "favors the Aiken bill (S712) provided that it be amended to define the duties of the department; to protect states rights and to include all health services in a single division." Wide latitude and flexibility should be authorized to the secretary of the new department and there should be no "professional limitations" in order to insure good administration and coordination.

### Physician and Dentist Legislators

In the 80th Congress there are eight physicians and two dentists, one more physician and one less dentist than in the 79th Congress. In thirty state legislatures there are fifty-three physicians and sixteen dentists, while eighteen states report no physicians or dentists in their legislatures. Eighteen states have but one physician, while nine have two physicians serving this year, and three have four, five and six, respectively. The governor of one state is a physician. Twelve states have one or two dentist legislators. Two states report that they each have one chiropractor in the Senate. One legislator holds a degree of D.D.S. as well as that of M.D.

### Dr. Olin West Resigns

On April 2 the resignation was announced of Olin West as president-elect of the American Medical Association. Dr. West has not been in good health for the past two years so that his resignation before assuming the duties of president at Atlantic City this June does not come as a complete surprise to many of his friends.

Members of the Connecticut State Medical Society may recall that Dr. West was made an honorary member of this Society at the annual meeting of the House of Delegates on May 1, 1946, one month following his retirement as secretary and general manager of the American Medical Association. Dr. West was unable to be in Hartford on May 1 last year to accept the honor our Society conferred upon him.

Very few physicians since the days of Nathan Smith Davis have contributed more to organized medicine than has Olin West. His recent resignation brings to a close a quarter of a century of service to his fellow physicians and to the progress of medicine in the United States. He will be succeeded by Edward L. Bortz of Philadelphia, now vice-president of the Association.

### County Societies Plan New Homes

A number of county medical societies are planning new headquarters buildings to house their society's activities. One of the most recent is the Medical Society of the County of New York. The society has purchased a new home at 167 East 69th Street and alterations will be started in the very near future.

Another is the Wayne County Medical Society (Detroit). W. B. Harm, M.D., in the *Detroit Medical News* says, "Our David Whitney House is becoming an old building and the depreciation and upkeep is increasing greatly each year. As a Society, ways and means must be found for remodeling or improving the old building, or erecting one suitable for our service. This should include the housing of the medical library and an assembly hall."

A third is the Academy of Medicine of Toledo and Lucas County which is in process of raising funds for a new and ultra-modern society building. The Academy has owned its present home since 1925.



## Expanded Research Program of American Heart Association

Plans to expand research in hypertension, coronary diseases and rheumatic fever were announced on March 13 at a meeting of the National Advisory Committee of the American Heart Association held in New York City. To carry forward this program, the Committee also announced plans to establish 100 additional affiliated Heart Associations in key cities throughout the United States.

Emphasizing that diseases of the heart and circulation are responsible for one out of every three deaths in this country, Mr. Parkinson declared: "The need for intensive research in such neglected fields as hypertension, coronary diseases and rheumatic fever, is readily apparent. To reduce the toll taken by the heart diseases, it is essential that the results of such research be made available to individuals in every American community.

"In the United States there are 23 Heart Associations and Heart Committees affiliated with the American Heart Association. If the average citizen is to receive the full benefit of new research in the heart diseases, local organizations composed of leading heart specialists must be increased in number."

H. M. Marvin, M.D., executive secretary of the Association told the Committee that observance of National Heart Week brought about a tremendous increase of public interest in diseases of the heart and circulation. As a result of the campaign, he said, many communities have already indicated their interest in forming local Heart Associations. He also reported that during the past six weeks the American Heart Association has distributed several hundred thousand pieces of educational literature to individuals and groups in 46 states concerned with developing local programs to fight heart disease.

Outlining plans for financing the current program of the American Heart Association, David D. Rutstein, medical director, stated that the budget of the National Association for 1947 is \$561,000. Though the Association has made no direct public appeal for funds on a national basis this year, concentrating instead on public educational activities, individual contributions have been made by small and large donors directly to the American Heart Association, and through its local affiliates. A selective fund raising campaign is now in progress.

Paul D. White reviewed the history and program of the American Heart Association which was

founded in 1924. Howard B. Sprague, president of the New England Heart Association and secretary of the American Heart Association, discussed the recent reorganization of the American Heart Association under which provision was made for the admission of non physicians on the executive bodies of the American Heart Association which heretofore have been limited to leading specialists in diseases of the heart and circulation.

## Research Fellowships in Medicine for 1947-48

The Committee on Fellowships and Awards of The American College of Physicians has awarded five additional Research Fellowships in Medicine for the year which begins July 1, 1947. Notifications of appointment have been sent to the following physicians: Ward S. Fowler, M.D., Philadelphia; Arnold L. Johnson, M.D., Montreal; Mary A. Payne, M.D., New York City; Miriam M. Pennoyer, M.D., St. Louis; Philip F. Wagley, M.D., Baltimore.

Dr. Fowler will conduct studies of the pathological physiology of certain primary disorders, under the supervision of Dr. Julius H. Comroe, Jr., F.A.C.P., at the Graduate School of Medicine of the University of Pennsylvania.

Dr. Johnson will continue his investigation of the hemodynamics of congenital heart disease in the Children's Memorial Hospital and the Department of Physiology, McGill University, under the direction of Dr. Alton Goldbloom and Professor H. E. Hoff.

Dr. Payne will undertake at the New York Hospital, where she presently holds appointment as assistant resident in medicine, studies of hepato-renal factors in regard to shock and hypertension.

Dr. Pennoyer will investigate adrenal function in newborn and premature infants at the St. Louis Children's Hospital, under the direction of Professor A. F. Hartmann of the Washington University School of Medicine.

Dr. Wagley proposes to study certain mechanisms of hemolysis. These studies will be conducted at the Boston City Hospital, with the supervision of Dr. William B. Castle, F.A.C.P., and Dr. George R. Minot, F.A.C.P.

The first appointment to a Fellowship for this period, announced last December, was that of Dr. Tom Fite Paine, Jr., Aberdeen, Miss. Dr. Paine will

engage in studies of the chemotherapy of infectious diseases, with especial regard to the use of antibiotics, in the Thorndike Memorial Laboratory of the Boston City Hospital.

### A.M.A. Radio Developments

A 13 program series of transcriptions titled "Story of Surgery" is nearing completion and the release date will be announced by the Bureau of Health Education. This series relates the various phases of modern surgery.

Just released by the Bureau is a new series of transcriptions based on developments in medicine. The individual programs will vary from time to time but all are under the general title "Medicine Serves America." The series includes 12 to 14 recordings with time open for local announcements to fill a 15 minute period.

The four year old transcriptions "Before the Doctor Comes" have been brought up to date and dressed up with organ music. Thirteen new records have been cut and will replace the older series under the same title.

These additions make available approximately 190 transcribed programs.

The Board of Trustees has authorized commercial sponsorship of A.M.A. network broadcasts under conditions retaining control of program content and commercial announcements by A.M.A. Not acceptable as sponsors are drug companies, food manufacturers, appliance and cosmetic manufacturers or any others whose products might be under consideration by the scientific councils of A.M.A. Excluded also are certain organizations whose interests and objectives are not consistent with those of the Association.

### County Medical Society Officers Planning Atlantic City Conference

The first "Grass Roots Conference" of county medical society officers will be held in Atlantic City on Sunday, June 8, at 2:00 P. M., according to a call issued by the National Conference of County Medical Society Officers of the American Medical Association.

The tentative program:

#### I. Professional Relations Problems

- A. The Doctor and the Medical Society
- B. The Doctor and the Hospital

- C. The Doctor and the Specialty Boards
- D. The Doctor and Postgraduate Education
- E. The Doctor and Legislation

#### II. Medical Service Problems

##### A. Distribution of Medical Care

1. Prepayment Plans
2. Rural Health
3. Labor Union Programs
4. Hill-Burton Act and Health Centers
5. Fund Raising Groups

#### III. Public Relations Problems

- A. The Doctor and the Patient
- B. The Doctor and the Public

The theme of the conference will be: "Make the American Medical Association the Working Partner of Every Individual Physician." Thomas J. Danaher, M.D., of Torrington, is a member of the committee making arrangements for the event.

### Meeting on School Health Problems

The Joint Committee on Health Problems in Education of the National Education Association and the A.M.A. will meet May 12 through May 16. Health problems in schools, and particularly the revision of the book "Health Education," a textbook now in use in the schools, will be the principal topics on the agenda.

The Joint Committee welcomes suggestions on problems and plans related to school health work from state and county medical societies. All members of headquarters staff who are interested are invited to attend the meetings and are also invited to send to Dr. Bauer any suggestions as to problems they might want to bring before the Committee.

The consultants who will meet with the Committee this year are: Superintendent John L. Bracken, Clayton, Mo.; Ben Miller, PH.D., executive secretary, American Association for Health, Physical Education and Recreation; Anne S. Duggan, PH.D., Denton State Teachers College, Denton, Texas, and Nina B. Lamkin, director, Health Education, Nebraska State Department of Education.

Revision of "Health Education" is under immediate direction of Dr. Charles C. Wilson, professor of health and education, Yale School of Public Health, New Haven, Connecticut. There is a large advisory technical committee. The steering committee for the revision consists of Thurman B. Rice, M.D., chairman of the Joint Committee, Indianapolis; Bernice Moss, PH.D., vice-chairman, University of



California, Berkeley, California, and Dr. W. W. Bauer, secretary.

Dr. W. W. Bauer is completing 15 years of service on the Joint Committee. His term expires in May and he is ineligible for re-election. Dr. Dean F. Smiley, consultant on Physical Fitness, Bureau of Health Education, has been appointed by the Board of Trustees, A.M.A., for a five year term to succeed Dr. Bauer.

### **Dr. Foote to National Society for Prevention of Blindness**

The National Society for the Prevention of Blindness announces the appointment of Frank M. Foote, M.D., to the position of executive director succeeding Mrs. Eleanor Brown Merrill who is retiring. Mrs. Merrill has been associated with the Society for more than twenty-five years and has served as the executive director for the past eight years. She formerly held the positions of associate director and secretary.

Dr. Foote joined the Society's staff as medical director in 1946. He was formerly district health officer of the Kips Bay-Yorkville Health District of the New York City Health Department. Prior to that, he was chief of the Division of Local Health Administration, Connecticut State Department of Health. Dr. Foote is assistant professor of Public Health and Preventive Medicine at Cornell University Medical College.

A native of Great Barrington Mass., Dr. Foote holds degrees of B.S., M.D., and DR.P.H. from Yale University. During World War II, he served as a Major in the Medical Corps of the United States Army. Dr. Foote is a member of the American Medical Association, a fellow of the American Public Health Association, a member of the Harvey Society of New York City and of the New York County and New York State Medical Societies.

### **National Hospital Employee Retirement Plan**

The Pension Committee of the American Hospital Association has announced a retirement plan for hospital employees, sponsored by the Association and presented through the National Health and Welfare Retirement Association, Inc.

Through joint contributions from both employer (the hospital) and employee an annuity is purchased

each year for each worker covered. The accumulated annuities are later used to provide a monthly income for the employee after retirement. The amount of retirement income for each individual is determined by the sum of the annuities to his credit.

If the employee stops work before retirement, he may withdraw the total of his contributions plus credited interest at the rate of 2 per cent, as provided in the plan. In so doing, however, he sacrifices his rights to any retirement benefits. If he prefers, he may leave his contributions in the retirement fund, in which event the hospital's contributions which have been made for him will also remain in the fund, to be applied toward his retirement benefits. Therefore, the program is both a savings and a retirement plan during the time he is in the employ of the hospital. No contributions will be made after he stops work.

### **Dr. Hennessy Honored by France for Public Health Work During War**

Harold R. Hennessy, M.D., executive officer for the committee on professional relations, Council on Industrial Health, of the American Medical Association, has been honored with the title of Chevalier de l'Ordre de la Santé Publique of France.

Dr. Hennessy, who resides in Winnetka, Illinois, received the medal and scroll of the order for his public health work in France during the war. Part of the two years he served in the European theater were spent as chief public health officer, Civil Affairs Section of the General Staff of Communications zone, ETOUSA.

A holder of the Bronze Star medal, Colonel Hennessy in October 1945 was admitted to Knighthood in the Order of Orange-Nassau, degree of Officer of Swords, by special decree of Wilhelmina, Queen of the Netherlands.

### **Council on Pharmacy and Chemistry**

The Council on Pharmacy and Chemistry is revising its rules concerning submission of new drugs, to insure better control facilities in pharmaceutical firms. The Council will henceforth include basic requirements on control in the outline of information required. If these basic safety precautions are not met, and until they are, the Council will not accept the product. The revision as outlined here will be incorporated in the next reprint of the Council's "Official Rules."

The following re-elections are announced:

Council on Physical Medicine: W. E. Garrey, Nashville, Tennessee; W. W. Coblentz, Washington, D. C.; John S. Coulter, Chicago, Illinois.

Council on Foods and Nutrition: Philip C. Jeans, Iowa City, Iowa; C. A. Elvehjem, Madison, Wis.

Council on Pharmacy and Chemistry: S. W. Clausen, Rochester, N. Y.; E. M. K. Geiling, Chicago, Illinois.

In addition to the re-elections, a new member has been elected to the Council on Pharmacy and Chemistry. He is Dr. Paul R. Cannon of the University of Chicago, a renowned clinical pathologist who has done outstanding work in deficiencies and infections.

### Army Medical Library Acquires Celebrated Chinese Publication

The Library has acquired a copy of the celebrated Chinese Golden Mirror of Medicine (Yu Tsuan I Tsing Chin Chien) the original of which was published in 1749. The set contains an introductory volume and 90 volumes of text with numerous woodcut illustrations. Wong and Wu, History of Chinese Medicine describes this book as: "One of the best treatises on general medicine of modern times." It was written in two sections by a staff of eighty persons in compliance with an imperial order, the first on internal medicine consisting of 74 volumes, the second on general surgery consisting of 16 volumes.

The first 25 volumes contain corrections of the ancient classics of Chang Chung-Ching, the "sage" of medicine whose Essay on Typhoid was published in 217 A. D. The other volumes cover General Diseases, Women's Diseases, Children's Diseases, Smallpox, Surgery, Diseases of the Eyes, Method of Acupuncture and Moxa, Bone Setting and Orthopaedics. Special chapters consider Parasitology, Leprosy and Inoculation which is known to have been practiced in China since the Sung dynasty, during the reign of Emperor Teu Tsung, 1023-1063 A. D.

### Meeting of Psychiatrists and Neurologists

The Connecticut Society for Psychiatry and Neurology met March 20 at the Fairfield State Hospital. Approximately eighty members and guests attended. A regular business meeting at 5:45 was followed by dinner at 6:15. The scientific program at 7:15 included four papers on the lobotomy opera-

tion, summarizing recent experience with this procedure in the public and private mental hospitals in Connecticut. Arthur H. Jackson, M.D., president of the society, presided at the scientific session. Guests included psychologists, nurses, occupational therapists and staff consultants of the Fairfield State Hospital.

### A.M.A. Membership Hits Peak in 1947

The American Medical Association has 131,590 members and 72,243 Fellows as of March 1, 1947. To qualify as a Fellow, a doctor must be a member in good standing of the A.M.A., graduate of a recognized medical school, pay Fellowship dues and subscribe for *The Journal*. Formal application must be made to the Judicial Council for approval. Only those members who qualify as Fellows are eligible for election as officers, may serve as members of the House of Delegates, may register at the annual sessions of the Association or may participate in the work of its scientific sections.

### Dr. F. A. Ellis Added to Staff of Council on Pharmacy, Chemistry

Fred A. Ellis, M.D., has joined the staff of the Council on Pharmacy and Chemistry of the American Medical Association, Chicago. He will assist Austin E. Smith, M.D., secretary of the Council.

Dr. Ellis received degrees of B.A., B.S. and M.D. from the University of Minnesota. Before joining the council, Dr. Ellis did postgraduate work at the University of Minnesota Hospitals in obstetrics and gynecology. Prior to that time he spent several years in the army as a flight surgeon, and also had considerable experience in private practice and industrial medicine.

### Urgent Need for Medical Books in Foreign Areas

Medical students in Europe and Asia are in urgent need of reading material to carry on their education.

A collection of medical books of any period and journals (after 1939) in all languages is being made by the Association of Internes and Medical Students. This material will be sent to the China Aid Association and to the International Union of Students at Prague.

All books and journals that can be donated should be sent to: Malcolm Bagshaw, Yale School of Medicine, 333 Cedar Street, New Haven 11, Conn.



MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*  
EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven  
JOSEPH N. D'ESOP, New Haven

Veterans Administration

Veterans Administration will participate in a long range program of medical research to improve the treatment of veterans, Dr. Paul R. Hawley, chief of VA's medical service, announced recently.

The program also will aid VA in reducing the tremendous loss of manpower from disabilities by providing more knowledge of the treatment and cure of disabilities, and it further will help VA to forecast its own future medical needs, Dr. Hawley said.

The Army, the Navy, the U. S. Public Health Service and some of the nation's outstanding medical groups and doctors will cooperate.

In its development the program is expected to include:

- 1. Follow-up studies to further the knowledge of the natural history of diseases and the results of treatment.
- 2. Basic clinical studies to be carried out in VA hospitals and other institutions.
- 3. Statistical studies on mortality, morbidity and continued disability among groups with medical conditions of special interest to physicians and surgeons.

Dr. Hawley said the program will be geared to utilize and extend the vast war-time medical experience and records in a manner unprecedented in clinical medicine.

Small pilot studies already are being formulated to develop methods of procedure.

A special Committee on Veterans Medical Problems, including some of the nation's foremost doctors, is making an inventory of existing rosters of Army and Navy patients with conditions that merit follow-up studies.

This committee is offering to keep the rosters so that they may be available when needed. The lists will be used only with the approval of those who compiled them and appropriate credit will be given.

Some doctors who compiled lists of diseases and treatments during World War II will take an active part in the follow-up studies.

Army and Navy procedures of processing medical records will make it possible to construct statistically representative rosters for almost any disease or disability that might be under study.

Further, the centralization of Army and Navy health records of demobilized personnel will make it possible to develop suitable follow-up rosters.

Dr. Hawley said the greatest beneficiaries of such a research program will be the veterans, since new knowledge will be acquired to improve their medical care. He added that needs for therapy will be better understood.

"Moreover, the highest type of medical personnel will be attracted to service in VA hospitals through the encouragement of careful study and treatment utilizing the best that modern science offers," Dr. Hawley said.

The Army and Navy are interested primarily in obtaining information that will be useful in curtailing the great loss of manpower from disease and injury and in improving methods of treatment so as to reduce ultimate disabilities. Both have agreed to supply records, basic data and other assistance essential to the success of the research program.

The program grew out of a conference on post war research, called in April 1946, by the National Research Council at the suggestion of Major General Norman T. Kirk, the Surgeon General of the U. S. Army.

At the conference it was pointed out that the great wealth of medical information accumulated by the armed forces during the war could furnish the starting point for a series of clinical studies which would provide veterans with the best possible medical care in the years ahead.

The conferees agreed that medical knowledge in general also would be advanced.

The program then was formulated in broad out-

line by a National Research Council committee under the chairmanship of Dr. Edward D. Churchill, professor of surgery at Harvard University Medical School in Boston.

At Dr. Hawley's request, Dr. Lewis H. Weed, chairman of the Division of Medical Sciences of the National Research Council, appointed a Committee on Veterans Medical Problems to handle details of the research program.

Physicians of the Army, Navy, and VA desiring to submit formal proposals to the committee on suggested research and study projects may do so on special forms provided for those agencies.

All others may obtain forms and information from the Office of the Committee on Veterans Medical Problems, 2101 Constitution Avenue, Washington 25, D. C.

The committee includes:

Dr. O. H. Perry Pepper, professor of medicine, University of Pennsylvania Medical School, Philadelphia, chairman; Dr. Francis J. Braceland, Mayo Clinic, Rochester, Minn.; Dr. Churchill; Dr. Winchell McK. Craig, professor of neurosurgery, Mayo Foundation, University of Minnesota, Minneapolis; Dr. Michael E. DeBakey, assistant professor of surgery, Tulane University Medical School, New Orleans; Dr. Louis I. Dublin, vice-president, Metropolitan Life Insurance Company, New York City.

Dr. Morris Fishbein, editor, *American Medical Association Journal*, Chicago; Dr. Perrin H. Long, professor of preventive medicine, Johns Hopkins University, Baltimore; Dr. William C. Menninger, the Menninger Clinic, Topeka; Dr. J. Roscoe Miller, dean and associate professor of medicine, Northwestern University Medical School, Chicago.

Dr. Hugh J. Morgan, professor of medicine, School of Medicine, Vanderbilt University, Nashville; Dr. Cornelius P. Rhoads, director, Memorial Hospital (for the treatment of cancer and allied diseases), New York City; and Dr. Milton C. Winternitz, professor of pathology, Yale University Medical School, New Haven.

### Veterans Administration Physicians Make Discovery

Two Veterans Administration physicians from the Wadsworth General Hospital in California, writing in the March 1 issue of *The Journal of the American Medical Association*, report a new method

for the relief of patients suffering blood vessel diseases of the arms and legs with gangrene.

The method, it is reported, not only relieved the "intractable pain," but also cleared the gangrenous condition and, in some cases, prevented possible amputations.

The treatment is described in *The Journal* by Drs. Zolton T. Wirtschafter and Rudolph Widmann, who are from the Department of Medicine, Wadsworth General Hospital, Veterans Administration Center, Los Angeles. Physicians cooperating in the work included Roger O. Egeberg, chief of the medical service, Wadsworth General Hospital; B. O. Raulston, dean of the University of Southern California Medical School, and William H. Leake and Edmund R. Ware of the University of Southern California and Wadsworth General Hospital.

The new method consists of injecting into the patient's vein a substance called sodium ascorbate, which is related to vitamin C. This is followed by the intramuscular injection of a solution known as histidine monohydrochloride with the simultaneous injection under the skin of additional sodium ascorbate. The two organic compounds—sodium ascorbate and histidine monohydrochloride—are given every four, six, eight or twelve hours, depending on the severity of the patient's condition. In addition, all patients are given ascorbic acid or vitamin C by mouth each day.

It is believed that the body's reaction is a transformation of the histidine into histamine by the action of the ascorbic acid within the body.

This new method of treatment causes the body to produce histamine, classified as a chemical substance, which is known to cause a relaxation of the blood vessels and an increase of blood flowing through them. The authors believe it is the first time that this technique has been tried to produce histamine itself in the patient's own body for the purpose of treating disease.

Drs. Wirtschafter and Widmann tried their treatment on 11 patients suffering from various forms of blood vessel disease. Four of the patients were suffering from gangrene and in one of them diabetic gangrene involved the fourth right toe.

In reporting the results, the doctors say: "All of these patients have up to the date of this report responded favorably to the therapy described and have not required amputations. The relief of intractable pain has been dramatic in the persons afflicted



with it. The relief has occurred within six hours to three days after the institution of treatment. Patients with gangrene, regardless of the cause, have responded most quickly; all have described a sensation of increased warmth in the affected limbs. . . .

"Extremities exhibiting black, shriveled, hard, mummified toes have shown areas of rubor [color] in the affected parts 48 hours after the institution of therapy."

The doctors explain further that in all cases exhibiting gangrene, there was a gradual return of function of the extremities although sensation was slow in returning.

In two instances of a certain type of blood vessel disease "the response was rapid," the doctors state, adding: "The relief of pain, the sensation of warmth and an increase in temperature of the affected extremities were again observed."

The physicians say their technique is now being investigated for the treatment of many other diseases in which circulation has failed, including coronary artery disease, angina pectoris and hypertension, and other conditions related to a deficiency of histamine.

### **Dr. Howard A. Rusk Addresses Rehabilitation Association**

Properly trained disabled persons frequently perform tasks more efficiently than whole-bodied employees, Dr. Howard A. Rusk, head of the Department of Rehabilitation and Physical Medicine at New York University College of Medicine, told more than 200 persons at a recent meeting of the Connecticut Rehabilitation Association in the Southern New England Telephone Company auditorium in New Haven.

"Our back rooms and attics are full of handicapped people who could benefit themselves and society generally if they could obtain this training," Dr. Rusk, wartime chief of the Army Air Forces convalescent program asserted.

He said it was not the lack of initiative, but rather the lack of adequate opportunity which prevented their restoration to useful living, and added that this condition often leads these disabled to seek hospitalization when they really need training instead.

That training such workers is a "paying proposition whether you figure it out in dollars and cents or in terms of humanities," has been proved many

times, he said citing as an example the Ford Motor Company which employs more than 11,000 incapacitated workers.

Rapid strides have been made, also, in medical rehabilitation, Dr. Rusk pointed out. Whereas 50 per cent of tubercular patients in the United States formerly either died from the disease or suffered a relapse within five years of their hospital discharge, he said today this rate has been reduced to two per cent.

### **Dr. Schuyler Appointed Chief Medical Officer**

Appointment of Dr. Samuel A. Schuyler of New York City as chief medical officer of the Hartford Regional Office of the Veterans Administration was announced recently by Harry T. Wood, manager.

An Army Medical Corps veteran of World War II, Dr. Schuyler is a graduate of Stanford University and the University of London School of Medicine.

Following his internship at Harlem Hospital in New York City and a residency at Sea View Hospital, Staten Island, N. Y., he served as acting medical superintendent of the Triboro Hospital, Jamaica, L. I., and later as deputy medical administrator of the Triboro Queen's General Hospitals, Jamaica, L. I.

Dr. Schuyler served in the European theater for 26 months in combat with the 78th Infantry Division and as deputy chief public health officer in Bavaria with the U. S. military government. He held the rank of major.

### **Canteen at Newington**

The canteen at the Veterans Administration Hospital in Newington was recently opened under management of the newly organized Veterans Administration Canteen Service.

Formerly a concession, the hospital canteen will now be an official service of the administration. It is housed in a Quonset hut located on the hospital grounds for the exclusive use of patients and employees residing at the station. Merchandise which can be consumed on the premises will be sold to other employees and visitors. Thomas A. Whiteley, of Bridgeport, Army veteran, has been named manager of the canteen.

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## STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

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### INTERPRETATION OF QUANTITATIVE SEROLOGICAL TESTS FOR SYPHILIS

**A**TITRATION on each blood specimen that gives a reaction to the routine qualitative test for syphilis is now being made in the Bureau of Laboratories. This procedure was initiated several months ago but until recently titrations were made only when requested by physicians to aid them in following individual cases under penicillin therapy. Because of the demand this service is now being furnished to all physicians.

The quantitative report based upon the Mazzini flocculation test will show not only the reaction obtained with whole serum but also reactions obtained in serial dilutions 1:2, 1:4, 1:8, 1:16, 1:32 and 1:64 so far as necessary to show the end point, i.e., the dilution yielding a negative reaction. There will be no change in the performance or reporting of the Connecticut complement fixation test which will be made only upon the whole serum.

It is not possible to particularize when interpreting any given laboratory result but the following general statements are considered a reasonable approach to the interpretation of results of quantitative tests for syphilis.

#### SUSPECTED CHANCRE PRESENT

Place greatest reliance upon repeated darkfield examinations and take into account the appearance of the lesion and any history of exposure. It is always advisable to confirm the diagnosis by darkfield examination for *Treponema pallidum*. Serological tests are rarely positive during the first 3 weeks and may remain negative for the first 6 weeks. Usually after 5 weeks the quantitative tests show a rapidly increasing titer in the absence of treatment when repeat specimens are examined. When treatment has been begun and completed while the serologic test for syphilis (hereafter called STS) is negative, a positive serological test may never be obtained.

#### EARLY SYPHILIS

After the seronegative primary stage, untreated early syphilis—even when latent—is accompanied by strongly positive STS. Titers rising to or above 1:16 are expected; titers of 1:64 and above are not uncommon. In this stage serological response to specific treatment should show a reduction in titer. When a decline in titer is followed by a rise of more than one dilution (e.g., from 1:8 to 1:32), the probability is that the case will relapse clinically. If this rise in titer is confirmed by a subsequent STS, a serologic relapse has occurred and retreatment is indicated. It should be emphasized that reduction in titer is not coincidental with the administration of penicillin but usually occurs during the first few months (4 to 6 months) of the post-treatment period.

Chancres and secondary lesions of syphilis may be delayed or masked when cases of gonorrhea are treated with penicillin; therefore, all cases of gonorrhea should have repeated STS at monthly intervals for at least 3 to 4 months.

#### LATE SYPHILIS INCLUDING LATE LATENT

It would be misleading to make more than a few generalizations about the behavior of STS in late syphilis. Frankly positive tests are anticipated when there has been no past treatment. The titer of the blood reaction may, however, not be consistent from day to day; fluctuations are common. Because many cases of late syphilis occur among persons who have received treatment that was not adequate, the titer of the reaction obtained may not prove a reliable criterion for diagnostic purposes. Any reaction by any standard test should be supplemented by careful clinical examination and the taking of a searching history. When syphilis is strongly suspected, a spinal fluid should be examined to rule out neurological involvement.

When unexpected reactions are obtained in the

*A contribution from the Bureau of Laboratories and the Bureau of Venereal Disease of the Connecticut State Department of Health.*



absence of symptoms and past treatment, the diagnosis should be held in abeyance pending consideration of repeat findings (see below).

When a history of past treatment has been obtained, the physical condition of the patient and his history are more reliable guides than are STS on blood in deciding upon the need for further treatment.

Late syphilis under treatment does not follow any predictable serological pattern. Fluctuations in titer will occur even with continued physical improvement of the patient. Many cases may never become sero-negative even though the disease has been arrested.

#### NON SPECIFIC REACTIONS

Not all weak or doubtful reactions are non specific but non specific reactions seldom exceed a titer of 1:2 in a well individual unless induced by vaccinia. Higher titers in the absence of syphilis may result not only from yaws, malaria, leprosy or other diseases not prevalent in Connecticut but also from febrile conditions of any sort, upper respiratory infections, recent immunization procedures, etc. Always repeat the test when laboratory findings are suspected to have a non specific origin. If still in doubt, repeat the test at monthly intervals for three months. Prenatal cases having doubtful tests for syphilis should have repeated tests at monthly intervals until a decision as to the diagnosis has been made.

#### NEGATIVE TESTS

Repeat the test if suspected primary syphilis. Reactions may not develop until six weeks after primary lesion occurs.

It is expected that this new service to physicians will provide not only the needed laboratory follow up on cases of syphilis under penicillin treatment but also a means whereby weak and often non specific reactions may be singled out for the thorough clinical evaluation necessary to establish or to eliminate a diagnosis of syphilis. For example, tests by qualitative methods sometimes show healthy and presumably non infected individuals to have blood tests apparently as strongly positive as those of persons with secondary lues. In the majority of such cases, quantitative methods will show the presumably healthy individuals to have relatively low titers, sometimes negative in 1:2 dilution, while individuals with secondary lues will show titers of 1:16, 1:32, 1:64 or higher.

## Medical Research Grants

Medical Research grants amounting to more than two million dollars have been recommended for the approval of Dr. Thomas Parran, Surgeon General, United States Public Health Service, by the National Advisory Health Council. Grants are contingent upon appropriations by the Congress for the fiscal year 1948 which begins July 1, 1947.

Of the 193 grants that supplement existing funds of universities and other research institutions, the largest, \$105,800, was recommended for a study of syphilis by the Pan American Sanitary Bureau. Sums of \$52,454 and \$46,000 respectively, were slated for the study of malaria by the University of Chicago and Christ Hospital, Cincinnati, Ohio. Six other grants were above a \$30,000 level.

Research studies involved cover a diverse number of subjects including tropical diseases, biochemistry and nutrition, cardiovascular diseases, dental research, gerontology, hematology, pathology, physiology, surgery, antibiotics, tuberculosis, bacteriology, pharmacology, radiobiology, metabolism and endocrinology, sanitation, virus, and rickettsial infections, and public health methods. The use of grants in aid in pursuing these studies implies no degree of Federal control. The investigator may work with full independence and autonomy, submitting only a brief concise report of scientific progress annually.

An additional 55 grants were favorably considered but await modification of amount or further study by the Research Grants Division of the National Institute of Health before final action is taken.

The National Advisory Health Council is established by Congress and aids the Surgeon General in carrying out the research programs of the Public Health Service. It consists of 14 members, 10 of whom are experts, not otherwise employed by the government.

Grants to Connecticut recommended for approval are as follows:

Laurel Heights Sanatorium for study of tuberculosis .....	\$ 6,671.00
Yale University for study of tuberculosis .....	3,699.00
Yale University for study of virus and rickettsial diseases .....	1,998.00
Yale University for study in field of bacteriology .....	13,446.00

ANNUAL REPORTS  
OF THE CONNECTICUT STATE MEDICAL SOCIETY  
1946 - 1947

STATISTICAL REPORT OF THE SECRETARY

MEMBERSHIP

FAIRFIELD COUNTY

Membership—April 1, 1946 .....	486
New Members .....	44
	530
Died .....	7
Lost by resignation, transfer, dropped non- payment .....	14 21
	— —
Membership—April 1, 1947 .....	509

HARTFORD COUNTY

Membership—April 1, 1946 .....	615
New Members .....	66
	681
Died .....	10
Lost by resignation, transfer, dropped non- payment .....	10 20
	— —
Membership—April 1, 1947 .....	661

LITCHFIELD COUNTY

Membership—April 1, 1946 .....	78
New Members .....	18
	96
Died .....	2
Lost by resignation, transfer, dropped non- payment .....	2 4
	— —
Membership—April 1, 1947 .....	92

MIDDLESEX COUNTY

Membership—April 1, 1946 .....	76
New Members .....	8
	84
Died .....	1
Lost by resignation, transfer, dropped non- payment .....	3 4
	— —
Membership—April 1, 1947 .....	80

NEW HAVEN COUNTY

Membership—April 1, 1946 .....	636
New Members .....	78
	714

Died .....	9
Lost by resignation, transfer, dropped non- payment .....	34 43
	— —

Membership—April 1, 1947 .....	671
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NEW LONDON COUNTY

Membership—April 1, 1946 .....	128
New Members .....	9
	137

Died .....	1
Lost by resignation, transfer, dropped non- payment .....	9 10
	— —

Membership—April 1, 1947 .....	127
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TOLLAND COUNTY

Membership—April 1, 1946 .....	17
New Members .....	2
	19

Died .....	0
Lost by resignation, transfer, dropped non- payment .....	1 1
	— —

Membership—April 1, 1947 .....	18
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WINDHAM COUNTY

Membership—April 1, 1946 .....	38
New Members .....	10
	48

Died .....	3
Lost by resignation, transfer, dropped non- payment .....	0 3
	— —

Membership—April 1, 1947 .....	45
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TOTALS

Fairfield .....	509
Hartford .....	661
Litchfield .....	92
Middlesex .....	80
New Haven .....	671
New London .....	127
Tolland .....	18
Windham .....	45
Total .....	2,203
Associate Members .....	8

Net gain for year .....	126
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## SECRETARY'S REPORT — 1947 HOUSE OF DELEGATES

The year just ended has been the first full year of post war operation, and although in the early months a number of war influences held over, the Society's activities have now become adjusted in what can probably be considered a stable pattern. The membership has increased beyond the bounds of the most optimistic forecast and totals over 2,300, the largest number the Society has ever had.

Those of us who are constantly close to the Society's affairs have a better opportunity to see and place a value upon its objectives and progress than most of you have. But even to us, some of these operations do not become clearly defined for quite a time and it is this long range development which will be discussed particularly in this report.

Six years ago the advantages of a close alliance between the Society and the Connecticut Medical Examining Board were foreseen by Dr. Murdock, a member of the Board, and as a result the executive secretary of the Society became secretary to the Examining Board. This arrangement meant providing practically full time administration for the Board but it also, and more importantly, brought every prospective candidate for medical licensure to the State Medical Society for his first contact. The good effected by this system cannot be measured. Most of the candidates come to the office for interviews and information and it is a surprising but a nonetheless true observation, that these physicians newly come to our state are more familiar with the activities and services of the Society's office than are many members of this House of Delegates. It is common for these candidates to ask, even before they are settled here, how they may become members of the Society either by transfer or election. All this is a privilege and advantage that, I believe, no other State Society enjoys and is the outcome of far sighted planning. An unsound piece of legislation, which would do away with this smoothly working organization and place the administration of the Examining Board in the State Department of Health, is now pending in the Capitol. It is House Bill 1375 introduced under the sham of economy and every member of the Society should do his utmost to defeat it.

Some years ago, it became apparent that if the Society was to be of greatest usefulness and merit public confidence, it would have to develop a strong position in public affairs. Planning was begun to place a physician representative of this Society on every Board and Commission having to do with health and welfare at the state level. If such breadth of influence could be attained, medicine might take satisfaction from its willingness to accept public responsibility and might also realize a certain sense of security against intrusion of the state government into medical fields. It is now possible to report to you that this goal has been virtually achieved and that with one exception every state board and commission related even remotely to health and welfare includes a carefully selected member of this Society.

The voluntary health and welfare agencies with statewide operations also presented areas into which it appeared that the Society should extend its interest and cooperation. This has been largely accomplished and with the addition of two especially trained and competent full time persons to the staff of the Society, some steps in this progress became easier.

During the past year, Miss Mooney has become a member of the Boards and Executive Committees of a number of organizations and in a like manner, Mr. Burch has become identified with veterans organizations, particularly in the field of rehabilitation and in public understanding of veterans' medical care. The value of relationships such as these and the extent to which they further confidence in medicine in our state cannot be estimated.

The Society's program in public relations was reorganized during 1946 and progress has been steady and substantial. Always an effort has been made to separate the clearly understood aims of publicity and the less tangible and sometimes ephemeral purposes of public relations. Even experts will admit that they do not know just what is meant by public relations. Often spectacular programs which give great satisfaction to the promoter but are of questionable worth, are proposed and I believe you will agree that our Society cannot afford to engage in such affairs, bright as they may appear and that nice discernment must be used. The value of our services in public relations and public education will increase as our knowledge and experience in this highly specialized field extend. On many occasions the public relations section has assisted county associations, and the Woman's Auxiliary in handling publicity and promotion. This service is always readily available to you and we seek the opportunity to help.

For some time two important phases of internal administration, accounting and extension of the personal record files of Connecticut physicians, both members and non members, have been carefully studied. In addition to keeping its own accounts, the Society now collects the county and state dues for five of the component associations thereby providing at least the credit side of accountnig for them and simplifying the duties of their secretaries. Our funds are under constant audit by certified accountants and the financial operations have reached a high degree of efficiency under Mrs. Lindquist.

The maintenance of files for nearly 3,000 physicians in the state is a complex and unending task. Changes in the Society's biographical records are made every day and during the year hundreds of new ones have been added and others revised by Mrs. Lipton who supervises our files. Here again there is great advantage in having access to the records of the Medical Examining Board which are compiled by Miss Noone who is also a part time employee of the State of Connecticut. These financial and personal records are unspectacular matters that you may never think of, but they are of the highest importance and almost every day we receive inquiries about the record and location of physicians. These inquiries come from the state itself and from all kinds of agencies and organizations interested in medical care. This is another public service from which the Society may well take satisfaction.

Our members do not always realize the economies offered them through group coverage in professional liability insurance, health and accident insurance and participation in Blue Cross coverage which was made available last year. Professional liability insurance is considered a necessity for physicians engaged in practice and the Society's group covers a large proportion of the membership. It should be emphasized that because of the close working relationship with our insuror, the premium paid for this coverage under the



Society's contract is probably lower than that in any other state and the average premium paid for this insurance as compared with the individual policy rate saves our member more than their county and state dues each year. It may be said exactly that most members pay about \$20 a year for this group insurance which if purchased singly would cost \$45 to \$50 for the protection obtained.

Increasing recognition is being given members of this Society in medical affairs outside of Connecticut. Dr. Miller continues in the high position as a Trustee of the American Medical Association; Dr. Weld is chairman of the Cooperative Medical Advertising Bureau for all state medical journals; Dr. Murdock is distinguished as a member of the small national committee arranging the Centennial of the American Medical Association which will be held in Atlantic City in June; Dr. Norman Gardner serves on the National Committee on Rural Medical Service and Dr. Thomas Danaher has lately been appointed to the committee planning the first national conference of county association secretaries which also will be held in Atlantic City. This is evidence that there are competent people in Connecticut and that their competence is known and utilized abroad. It is your secretary's privilege to serve as a member of the Executive Committee of the Federation of Medical Examining Boards of the United States.

I would like to make additional mention of the Committee to Study the Organization and Objectives of the Society. If an expanding enterprise, such as this Society is, is viewed candidly, it will be seen that its solid growth requires three somewhat independent but inseparable kinds of thinking. First, the over all policy making and direction which is done by the Council elected by the constituency, second, carrying out the purposes laid down by these directors which is the function of the executive staff and third, which is a fresh realization, study of the operations and objectives of our business and long range planning. The new Committee under Dr. Bishop can fulfill this requirement. Its review of what the Society is doing and how it is doing it should produce recommendations for the improvement of our operation and increase the Society's usefulness to its members and to the public. Further, it is likely that it will be found desirable to have a permanent committee which will continuously propose for the consideration of the Council new projects for the Society, perhaps new ways to do the things already being done.

Finally, in all of these developments and in every activity of the Society, the greatest credit must be given to the unremitting work of the Council and several committees. The advice and guidance that is received from them is the base upon which all progress has been made and the full value of the time and thought that is given to the Society's affairs by the loyal members of the Council and these committees should be appreciated by every member of this Society. There arises sometimes, it seems, the idea that the administration of the affairs of the State Medical Society is something apart from the physicians in this state when actually the reverse is true. The Society is the physicians in the state, it is a voluntary organization of the individuals in the county associations united in a common purpose and if continued progress is to be made, each county association and each individual must have his voice and realize his responsibilities.

## REPORT OF THE CHAIRMAN OF THE COUNCIL

Mr. President and Gentlemen of the House of Delegates:

This is a continuing report and covers the important activities of the Council only since the midwinter meeting in December 1946 and therefore is brief.

At the House of Delegates meeting in December the Council was instructed to appoint a committee to again study the controversial question of the Workmens Compensation Law. This committee was appointed and is made up of Drs. A. H. Bissel, Chairman, Thomas Soltz, E. F. Carniglia, C. H. Cole and J. F. Kilgus. It is a strong committee and the Council believes its studies will be completed in time to report at the midwinter meeting of the House of Delegates.

Following the endorsement of the National Physicians Committee by the House of Delegates at the midwinter meeting the Council proceeded with a plan for the appointment of a committee to cooperate with the National Physicians Committee.

The Council believes it desirable to enlarge the Board of Trustees of the Building Fund and divide the Board into three sub groups, one group to complete solicitation of members, a second group to seek memorial gifts, and a third to proceed with planning and construction of the building.

The Council calls to the attention of the members the very valuable work that the committee on Medical Care of Veterans has done. This committee is to be continued as a reference committee to settle any disputes developing between our members and the Veterans Department.

The Council is justifiably proud of the nominees it presents to you for election and feels sure that they will bring honor to the society. The Council calls your attention to the intensive study made each year in its attempts to nominate representative men to the various committees. It becomes increasingly apparent that the councilors must be familiar with the medical men in their counties in order that the best men available shall be obtained for these positions. In October the Council instructed the secretary to write each county medical society to recommend members for these committees. Only two county societies responded. This is unfortunate. It is obvious, I think, that the Council must depend on the officers of the county societies and the councilor from each county for this very important and necessary information.

The attendance of the councilors has been excellent. Three have attended all meetings; seven have been absent once; two absent twice; three absent three times. In every instance a sound excuse was presented. The duties of a councilor is time consuming and trying. All of the difficult problems of the society are referred to the Council. They have been diligent and loyal and ever jealous of the reputation of the society. I ask your appreciation of their efforts.

My report would be incomplete if I did not call to your attention again the loyalty of the headquarters staff. One wonders what if any progress the society would have made if it had not been for the drive and untiring effort of the secretary, Dr. Creighton Barker. His assistant, Dr. Grace Mooney, has contributed a great deal to the society. The other members of the staff have all aided in placing the society in its proper place not only in the state but in the nation.

Respectfully submitted,  
T. P. Murdock



## REPORT OF THE TREASURER

Mr. President and Members of the House of Delegates:

A comprehensive report showing the financial activities of this Society, for the year ending December 31, 1946, has again been prepared by Seward and Monde, Certified Public Accountants and will be published in an early issue of the Connecticut State Medical Journal.

Total current funds on December 31, 1945 amounted to \$50,438.87. On December 31, 1946, this item amounted to \$56,077.80, a gain of \$5,638.93.

During the year new activities necessitating additional expense were initiated, some previously established were elaborated and extended and economic trends made increases in salaries advisable. Notwithstanding these additional obligations, the excess of income over expense was the amount stated. A word of explanation will give some of the reasons for this happy situation:

Dues received for the year 1945 amounted to \$28,068.75. Anticipated for the year 1946 was \$30,000. The total received for the past year was \$32,403.13, more than \$2,400 over what was anticipated.

Again this past year, the Journal gave evidence that it is not only outstanding as a scientific and literary Journal, but continued its fine record of financial success. Its cost of production for the year was \$23,634.91. Its income for that period was \$25,695.51—a profit of \$2,060.60. Surely, this is a great record in a year of high costs, both in labor and material.

A third reason for the Society's financial success is the fine quality of administration in the State Office. This report is made possible by the fine services rendered by Dr. Barker and his efficient staff. To them all, I give my thanks.

However, in the final analysis, the County Societies and their members make the State Society and its program possible. It should make us all proud to know that in an organization of 2237 members, the total number of delinquents on December 31, 1946 was not more than 1 per cent.

You will be happy to know also that on March 20, 1947, 73.2% of the total membership had paid their dues for 1947. With such cooperation any Society must succeed.

I should like to include with my own, the thanks of the Society to the Council for its guidance and to Seward and Monde and the Second National Bank of New Haven for their courteous cooperation and service.

Respectfully submitted,  
Hugh B. Campbell

REPORT OF THE EDITORIAL BOARD OF THE  
CONNECTICUT STATE MEDICAL JOURNAL

Stanley B. Weld, <i>Editor-in-chief</i>	Frank S. Jones
Herbert Thoms, <i>Literary Editor</i>	Paul P. Swett
Lee D. Van Antwerp	Harold S. Burr,
	<i>Associate Member</i>

Mr. President and Members of the House of Delegates  
Gentlemen:

One year ago we looked forward to our first year in several, free from the exigencies of war. But this freedom has left much to be desired in the business world and your Journal has

a stake in this world. The cost of everything has steadily been climbing with the rental charge for office space surpassing everything else, even newsprint. We have continued to be indebted to our printer, Whaples-Bullis Company, New Haven, for keeping us supplied with a sufficient quantity of a good grade of paper. Never have we been forced to apologize for this article.

Board meetings have not been resumed, more due to the apparent shortage of available time for the editors, but the editors and the Society's secretary have continued to meet monthly to plan the content of each issue. The final conference between the editor-in-chief and the printer as each issue is put to bed has been continued each month. The results of this attention to detail should be apparent in the finished product.

Another member has been added to the office staff, Miss Myra Ferriera. For several months now Mrs. Hume has been employed on a part time basis, coming in for the busier periods of preparing the dummy, billing the advertisers, and other special assignments. Miss Ferriera has shown a willingness to learn the details of the operation of a journal office which has been very gratifying and helpful.

The Journal itself has changed little from previous years. "Letters from Members in the Armed Forces" ended its career in May and "Medicine and the War" stopped with the September issue. "The President's Page" has become a regular monthly feature. Peripateticus is a more frequent contributor and the "Doctor, Inform Your Patients" page has been continued with emphasis on definite points in public relations. Dr. Thoms again has shown his interest in historical medicine by wisely deciding to publish in book form Dr. Paul P. Swett's delightful "History of Orthopedic Surgery in Connecticut" which ran in two consecutive issues of the Journal. This makes the third book published by the Journal.

1946 was a banner year for advertising. The Journal carried some advertising copy which has been rejected for 1947 since, with the liberalization of the rules of the Council on Pharmacy and Chemistry, it is endeavoring to abide by the standards set up by the Cooperative Medical Advertising Bureau of the American Medical Association. In 1946 the Journal realized an actual profit, but a repetition of this successful result following a year of exceptional advertising business is not anticipated. It was a thrill while it lasted.

The editor-in-chief has served during the past year as chairman of the Advisory Committee of the Cooperative Medical Advertising Bureau. This task has been an instructive one and has brought with it the opportunity to become more intimately acquainted with State medical Journal editors across the country, in itself of inestimable value.

During the absence from the State of the editor-in-chief on two occasions the arranging of the issue has been done by one of the Board, Dr. Lee Van Antwerp. Since Mr. James Burch joined Dr. Barker's staff in the New Haven office he has been of assistance to the Journal staff in supplying material for publication and in assisting in the final arrangements of the product. Many members have assisted with book reviews and several county news editors continue to do a valuable job. To all these and many more we express our grateful appreciation. The Connecticut State Medical Journal marches on.

Respectfully submitted,  
Stanley B. Weld

# REPORT OF THE COMMITTEE ON MEDICAL EDUCATION AND LICENSURE THE CONNECTICUT MEDICAL EXAMINING BOARD

Charles J. Bartlett, *President*

John D. Booth

John C. Rowley

Thomas P. Murdock

George M. Smith

The year 1946 was one of unprecedented activity for the Connecticut Medical Examining Board. During the year the Board held the six regular meetings required by the statutes and thirteen special meetings. The largest number of candidates ever to appear before the Board was considered. The statistical analysis of the candidates, their educational qualifications and other data are appended to this report.

Changes in personnel have taken place in the Board; first by the untimely death of Dr. Daniel C. Patterson on September 12, and the termination of the appointment of Dr. John C. Rowley at the end of the year. Dr. Patterson became a member of the Board in 1933 and was the examiner in surgery. His interest in the affairs and operation of the Board was always keen and his contributions to its projects remarkable. Upon recommendation of the State Medical Society, Governor Baldwin appointed Dr. John D. Booth of Danbury to serve the remainder of Dr. Patterson's term. Dr. John C. Rowley became a member of the Board in 1916 and had served with the Board longer than any other member. His term of appointment ended on December 31 and upon recommendation of the State Medical Society, Dr. Wilmot C. Townsend of Hartford was appointed his successor for a term of five years.

During the year four physicians were brought before the Board for hearing. In one instance the license was revoked, two formal reprimands were imposed, the fourth physician was exonerated of the charges.

Fifty-six candidates appeared before the Board for written examination. Forty-five candidates were successful and were recommended for licensure, of whom forty-two were graduates of medical schools in the United States and Canada and three were graduates of foreign medical schools. Eleven candidates failed to pass the examinations, three of whom were American graduates and eight were graduates of foreign medical schools. Of the fifty-six candidates who appeared, fifty-two were male and four were female. The list of schools represented and the number of candidates from each follows:

<i>School</i>	<i>Passed</i>	<i>Failed</i>	<i>Total</i>
Columbia P & S	3		3
Cornell	1		1
Georgetown	2		2
Harvard	2		2
Jefferson	3		3
Johns Hopkins	2		2
Long Island College of Medicine	2		2
Louisiana State University	1		1
Loyola	1		1
McGill	3		3
Meharry	1		1
New York University	1		1
Pittsburgh	1		1
Stanford University	1		1

<i>School</i>	<i>Passed</i>	<i>Failed</i>	<i>Total</i>
Tufts	1		1
University of Arkansas	1		1
University of Chicago	2		2
University of Cincinnati	1		1
University of Maryland	3		3
University of Montreal	1		1
University of Oklahoma	2		2
University of Rochester	1	1	2
University of Vermont	2		2
University of Pennsylvania	1		1
Western Reserve	1		1
Yale	2	2	4
<i>Foreign Schools:</i>			
University of Athens		1	1
University of Bern		1	1
University of Bologna	1	1	2
University of Geneva		2	2
University of Havana	1	1	2
University of Vienna	1	2	3
	—	—	—
<i>Total</i>	45	11	56

Three hundred and seven candidates were recommended for licensure on the basis of endorsement of credentials presented. Two hundred and eighty-one of the credential candidates were graduates of medical schools in the United States and Canada and twenty-six were foreign graduates. Two hundred and ninety-nine of the candidates were male and eight were female.

Credential candidates represented seventy-one medical schools as follows: Yale—41, Tufts—27, Long Island—16, Columbia P & S—16, New York Medical College—15, New York University—13, Harvard—13, Cornell—11, Vermont—11, Boston University—10, Georgetown—9, Johns Hopkins—7, Syracuse—7, McGill—6, Cincinnati—6, University of Maryland—6, University of Chicago—4, Albany Medical College—4, Jefferson—4, Rochester—4, with less than four candidates from each of the following schools: University of Tennessee, Western Reserve, Creighton, Washington University, Meharry, Howard, Ohio State University, Louisiana State University, College of Medical Evangelists, Buffalo, University of Colorado, Louisville, Dalhousie, Duke, Temple, Wayne, Arkansas, Western Ontario, Baylor, George Washington, Women's Medical College of Pennsylvania, Toronto, Laval, Iowa, Medical College of Virginia, Nebraska, Indiana, Tulane, Stanford, St. Louis, Minnesota, University of Pennsylvania, University of Wisconsin; and the following foreign schools: Vienna—5, Bologna—3, Bern—3, Basle—1, Graz—1, Zurich—1, Cambridge—1, Geneva—1, Lausanne—2, Edinburgh—1, Beirut—1, Strassburg—1, Breslau—1, Sheffield—1, Warsaw—1, Munich—1 and Budapest—1.

Endorsement candidates presented the following credentials: National Board of Medical Examiners—146, New York—74, Maryland—12, Ohio—11, Pennsylvania—8, Massachusetts—7, Minnesota—5, Vermont—5, Maine—4, California—3, Tennessee—3, New Jersey—3, Michigan—3, Illinois—3, North Carolina—2, Louisiana—2, Wisconsin—2, Iowa—2, West Virginia—2, Arkansas—2, Virginia—1, Indiana—1, Rhode Island—1, Colorado—1, Missouri—1, New Hampshire—1, Texas—1, Mississippi—1.



Seven examinations in medicine and surgery were given to Doctors of Osteopathy; i.e., 3 examinations in medicine, all of whom were successful and recommended for licensure to practice medicine; four examinations in surgery, with three successful candidates who were recommended for licensure to practice surgery, and one unsuccessful candidate in surgery.

REPORT OF THE COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Edmund L. Douglass, *Chairman*

- Charles H. Sprague  
Benjamin B. Robbins  
W. Bradford Walker  
Frank H. Couch
- Charles T. Flynn  
John E. Flaherty  
Brae Rafferty

The Committee scheduled its regular meeting for the review of legislation pending before the General Assembly for Sunday, March 2, and this had to be postponed because of heavy snow. As time went on and progress was made by the General Assembly it was for a time thought possible that the Committee would not have to meet but that questions from the Executive Secretary relating to legislation could be handled by telephone.

Later it was decided that a meeting of the Committee was required and that meeting was held at the office of the Society on March 24. The Chairman and five members of the Committee were present and the Executive Secretary. Two members were absent.

Seventy legislative bills introduced before the Connecticut General Assembly which had been analyzed by the staff of the Society's office were discussed, some in great detail. Decisions in regard to many were easily reached while others required careful consideration. Formal votes were finally taken to determine the Society's stand on a bill to provide a commission to study health insurance. It was determined that the Society should take no stand on this proposal.

S. B. 742 which would permit free choice of physicians in hospitals by injured employees under the Workmen's Compensation Act was discussed at length and the results of an inquiry made by the Executive Secretary were presented to the Committee. On a three to one vote of the Committee, with one member not voting, the Secretary was directed to record the Society as being in favor of the legislation.

Respectfully submitted,  
Edmund L. Douglass

REPORT OF THE COMMITTEE ON NATIONAL LEGISLATION

Oliver L. Stringfield, *Chairman*

- Benedict R. Harris
- Ralph M. Tovell

Since the last report there have been quite a number of medical bills which have appeared in congress. The most important of these from our standpoint has been: S140 and S545. Your committee through the state office sent a vig-

orous message to Washington opposing S140. Since this bill does not accomplish the purpose we wished relative the correlating of all medical agencies under one administration. This bill would have a lay administrator of cabinet rank under which would be three agencies: medical, educational and social. The medical agency would be directed by a physician. However, the Children's Bureau would be placed under security and nothing in the bill makes an effort to gather together the other agencies dealing with medical matters. Senate Bill 545 introduced by Senator Taft has a great deal which is advantageous. There are some points which are not correct but we believe could be straightened out. The most important part of this bill is that it brings all agencies dealing with medicine under one administrator who must be a physician with outstanding qualifications in medicine. This seems much more desirable than that under S140. Your committee has been alert watching these bills and has made the necessary recommendations to Washington.

Respectfully submitted,  
O. L. Stringfield

REPORT OF THE COMMITTEE ON HOSPITALS

Louis P. Hastings, *Chairman*

- William H. Curley  
James C. Fox  
John P. Hanley
- Robert R. Nesbit  
Harold W. Wellington

The Committee on Hospitals adhered to no regular schedule of meetings during the past year.

Joint meetings were held with the Commission on the Chronically Ill and the Trustees of the Connecticut Hospital Association respectively. We agree with the Commission that the care of chronically ill patients should be in close physical contact with existing hospital facilities as the best means of providing two important necessities, adequate medical staffs and laboratory facilities. To do otherwise would appear to require unnecessary and expensive duplication. The manner in which such physical facilities can be made available would seem primarily a problem of the Hospital Association and the Commission.

The meeting with the Trustees of the Connecticut Hospital Association was held to discuss a proposed plan for partial subsidy of the hospital care of low income patients by the state. This well conceived plan presented many problems of detail and would appear, at present, to require further study before being carried to completion.

At the present time, the committee is watching, with interest, a growing effort being made by some hospitals to solve the problem of nursing shortages. A recent bulletin from the American College of Surgeons suggests that the training of "nurses aides" or "assistants" might help in this matter. One Connecticut hospital now contemplates such a program of training and the reaction of the nursing profession and its Board are being closely followed.

Respectfully submitted,  
Louis P. Hastings

## REPORT OF THE COMMITTEE ON INDUSTRIAL HEALTH OF THE CONNECTICUT STATE

A brief semi-annual report of this Committee was presented at the meeting of the House of Delegates, December 30, 1946 and published in the February issue of the *JOURNAL* of the Connecticut State Medical Society. The Committee has met regularly the fourth Wednesday of each month at 7:00 P. M. in the offices of the executive secretary of the Connecticut State Medical Society since the last report was made. All meetings have been exceptionally well attended.

Dr. Cole B. Gibson and Dr. James R. Miller honored the Committee with their presence by attending the January meeting. Dr. Gibson was very complimentary in his remarks with regard to the work being done by this Committee. Much of the credit for the growth and increased activity of this Committee must be given Dr. Gibson, since he was one of the original and pioneer members of the Committee.

Dr. Miller gave an excellent report on the status on Pre-paid Medical Insurance Plans in Connecticut. He was quite pleased with the interest shown by the members of this Committee and their efforts in connection with insurance plans in industry.

It is gratifying to report that the efforts of this Committee during the past few years have been rewarded. Early in the fiscal year the Yale University School of Medicine announced the opening of a new Division in the Medical School called the Institute of Occupational Medicine and Hygiene. Dr. Ronald F. Buchan, now a member of this Committee, was appointed Clinical Director. The activities of the Institute during its first year have gone far beyond expectations. The Postgraduate Course on Industrial Medicine given under the auspices of the Institute has been exceptionally well attended. The course began February 4 and ended April 8. With a few exceptions, all the members of this Committee were registered for the course.

Dr. Clarence D. Selby, chief medical consultant of the General Motors Corporation, was procured by this Committee as the principle speaker for the Industrial Health Sectional Meeting at the Annual Meeting of the Connecticut State Medical Society in Hartford, May 2, 1946. Dr. Selby's subject was "Sickness Trends in Industrial Groups." He discussed the newer concept of industrial medicine with respect to the important role the industrial physician must, can, and does play in disease prevention; non occupational as well as occupational. He pointed out that there were still physicians and business executives who were under the impression that the industrial physician could function only in the curative field.

This Committee took a very active part in the Seventh Annual Congress on Industrial Health, September 30, through October 2, 1946 at the Copley Plaza Hotel, Boston. The meeting was jointly sponsored by the Council on Industrial Health of the American Medical Association, Council of New England State Medical Societies and the Massachusetts Medical Society.

The Committee also took a very active part in the program of the Connecticut Safety Society, Inc., at its Second Annual Connecticut Industrial Safety Conference at the Hotel Bond,

Hartford, March 5, 1947. Dr. Crit Pharris gave a paper on "The Nurse's Participation in Accident Prevention," and Dr. Philip J. Moorad gave a paper on "Psychology of Accident Repeaters." Dr. Albert S. Gray and Dr. John N. Gallivan participated as chairmen at different sessions for this meeting.

For a little more than a year the regular monthly meetings of this Committee have included the presentation and discussion of industrial medical and scientific subjects. This type of meeting has grown to the point where industrial executives have become extremely interested in the subject of Industrial Medicine and Hygiene. The joint meeting in Waterbury with the executives of the American Brass Company was a huge success. This interest and enthusiasm on the part of industrial executives have encouraged the Committee to develop a similar program to include other industries in this State. The plan has come to the attention of the Council on Industrial Health of the American Medical Association and the Council is very much interested. Dr. Carl M. Petersen, secretary of the Council on Industrial Health of the American Medical Association, is planning to give some publicity to the Connecticut Plan in the *Journal of Occupational Medicine* of the American Medical Association.

Several meetings have been held with subcommittees of the Industrial Division of the Connecticut Nurses' Association during the past year to discuss industrial medical and nursing problems.

The members of this Committee have taken a very active part in the State Legislature during the past year in matters concerning industrial nursing and occupational medicine.

This Committee is studying a plan suggested by Mr. James Burch, director of Public Relations of the Connecticut State Medical Society, for the distribution of Industrial and Occupational health information to the public. Mr. Burch suggested the possibility of the formation of a Council on Medical Information to take care of releasing the information. Weekly columns would be sent to the many weekly newspapers throughout the State containing helpful health information. This material would be directed from the Council on Medical Information to the Public Relations Committee for actual release. Mr. Burch described a similar plan now being employed by the Indiana State Medical Society.

I would like to express my deepest appreciation to all the members of this Committee for their splendid work during the past years. Their untiring efforts and enthusiasm have been responsible for making it successful. To the chairmen of the following subcommittees, I wish to express my sincere thanks:

- Dr. Martin I. Hall—Conference—Forums—Seminars.
- Dr. Albert S. Gray—Editorial.
- Dr. Arthur B. Landry—Legislation and Jurisprudence.
- Dr. Crit Pharris—Public Relations.
- Dr. Andrew J. Jackson—Industrial Nursing.
- Dr. James H. Biram—Medical Ethics.
- Dr. Robert P. Knapp—Liaison.
- Dr. John N. Gallivan—Development and Membership.
- Dr. John R. Paul—Education.

Respectfully submitted,  
C. F. Yeager



## REPORT OF THE COMMITTEE ON PUBLIC HEALTH

Howard S. Colwell, *Chairman*

Joseph A. Beauchemin	Karl T. Phillips
Donald A. Bristoll	J. Harold Root
John W. Buckley	Howard G. Stevens
Daniel Corrigan	Maurice J. Strauss
Jessie W. Fisher	Oliver L. Stringfield
Joseph I. Linde	Carl L. Thenebe
Luther K. Musselman	Carl H. Wies

Friend L. Mickle, *Associate*

Continued interest is obtaining for smaller communities of our State increased facilities for maintaining and improving the public health through Full Time Health Service led to the presentation to the House of Delegates, at the December meeting, of our endorsement of the principle of Full Time Health Districts under the supervision of Full Time Health Officers. It was further recommended that the House of Delegates approve and support the Bill to be introduced into the 1947 legislature providing for financial assistance by the State to towns voluntarily uniting for the benefits of a full time Health Service.

For many years this Committee, especially while under the Chairmanship of Dr. Joseph Howard, has been aggressively active in the observation of facts relevant to maternal morbidity and mortality in Connecticut, and has been constant in following up every opportunity to aid in the improvement of our excellent relative position in obstetrical practice. Because of the desirability of having continuous supervision of this situation, the Council of the Connecticut State Medical Society was requested to name five obstetricians as a Committee on Maternal Mortality and Morbidity. This has been done.

In co-operation with the Committee on Public Relations and the Public Relations Director, this Committee is working out plans toward more effective means of getting to the public accurate and timely medical information especially through the avenues of daily and weekly newspapers in our State.

Under the auspices of the Academy of Pediatrics, the survey of available medical care for children is nearing completion. This should bring to light important facts about the situation in Connecticut. This information, together with data already obtained by the Crippled Children Division and Bureau of Child Welfare of the Connecticut State Department of Health should be a sound basis for any changes toward the betterment of facilities and personnel for child care in Connecticut.

Under the supervision of the Public Health Committee are sub-committees on Crippled Children Program, Obstetrics, Pediatrics, E. M. I. C., Vision and Hearing. Each of these co-operates with the Connecticut State Department of Health in numerous activities such as supervision of Well-Child Conferences, appointment of consultants for E. M. I. C. Program and Obstetrics, and Pediatrics Consulting Service. The Crippled Children's General Advisory Committee, under the Chairmanship of Dr. Paul P. Swett, has given much consideration to the establishment of Crippled Children's Clinics in areas not now covered, and the need in related fields for other consultation clinics for children; to provision for adequately trained personnel; and problems incident to the steady annual

increase in clinic case loads. Their Rheumatic Fever program includes plans for continuation of the fact finding survey concerning incidence, necessity for consultation and extent of care in a single pilot city, along with opportunities for convalescent care throughout the State.

The Public Health Committees will be increasingly interested in the opportunities and techniques for Health Education, especially in effective cooperation of the existing health agencies in this field.

The responsibility of all the members of the State Society for willing acceptance of leadership in this field of Health Education is apparent and proper.

Respectfully submitted,  
Howard S. Colwell

## REPORT OF THE COMMITTEE ON PUBLIC RELATIONS

C. Charles Burlingame, *Chairman*

Howard S. Colwell	Wm. Mac Shepard
Thomas J. Danaher	Hugh Wilson
George H. Gildersleeve	C. Frederick Yeager
Ralph W. Nichols	

Howard W. Haggard, *Associate*

During the past year a full time Public Relations Director was added to the staff of the Society and after his coming, the Committee on Public Relations concerned itself more with policy making than with operations. Since the House of Delegates is more interested in what has been done than what has been planned, it is appropriate that the report for the Committee be prepared and presented by Mr. Bruch.

It is difficult to evaluate the intangible thing called "Public Relations" in terms of tangible accomplishments but accomplishments to date have seemed gratifying to those of us who have been close to the work.

Mr. Burch's report is well worth reading as it will convey to the membership a concrete idea of current activities. It might be added that all Public Relations efforts must be directed toward a long-range goal with activities and investments building one upon the other toward a sound, enduring relationship which should result in mutual benefits to medicine and the people.

Respectfully submitted,  
C. Charles Burlingame

## PUBLIC RELATIONS REPORT

August 1946 to March 1947

To simplify presentation, this report is dealt with in four parts: (1) Consideration of Planning; (2) Communications Media; (3) Co-operation with other organizations; (4) New Projects.

### I. CONSIDERATION OF PLANNING

It is appropriate to mention in the beginning that effective public relations cannot be measured solely by the quantity of printed literature produced. To flood the countryside with thousands of colorful leaflets is but a question of devoting to such an effort large enough sums of time and money.

Printed publications are valuable and necessary aids in any public relations program. Difficulties arise, however, when their function is over emphasized, when their use as a means of communication becomes an end in itself, and the groundwork of sound relationships is diminished in importance.

That groundwork exists in service, service to all the publics related to any particular enterprise. For the profession of medicine this base covers virtually all of the population. The situation is dissimilar to commercial ventures, which can handily label their publics as consumers—dealers—employees.

Good health is of fundamental interest to every person. Consequently, any service for the preservation or restoration of health which can be held out to the average individual provides a good ground for the growth of better public relations. Add properly written and adequate publicity to this basis of service and favorable public opinion and support should result.

These considerations have not been arrived at arbitrarily, and the principles involved are not new. They have been at work for many years as keys to sound programs of human relations in many fields. Perhaps they seem too simple for prolonged emphasis, but in this day of complexities it becomes ever more important to uncover and hold to fundamentals.

Accordingly, our present program is being aimed in the above direction to develop (1) communications with the people, emphasizing their interests in health and medical care, (2) initiation of auxiliary projects to supplement the valuable work being done by the State Medical Society and its committees, and (3) close coordination with welfare and health agencies to assist in the growth of programs for general health improvement.

## II. COMMUNICATIONS MEDIA

When the Society's plans were undertaken in August, 1946, a brief survey of the situation indicated that the first step should be the intensive cultivation of communications channels.

As the most adaptable and readily available medium in Connecticut exists in its excellent press facilities, both daily and weekly newspapers were chosen as the first field of action. Results have been better than anticipated, and are cited in another section of this report.

After this part of the program became solidly established, attention was turned to radio. Use of this medium has not been possible because of the relatively high costs involved for effective presentation, but continued study indicates its possible use in the near future.

### a. NEWSPAPERS

From August 20, 1946, to March 11, 1947, a total of 36 releases were written and published in Connecticut newspapers with the following results, as tabulated from clippings received:

Column inches published totalled 1,066, which would be equal to 53.3 columns of standard 20-inch length. It is estimated that clippings are only 85 per cent complete, which would increase the above to a usable figure of 61 columns. This represents 7.6 filled newspaper pages, over a period of slightly more than 6 months. Or, to picture the result as it actually occurs in newspaper publishing, this amount of copy would support the publication of a single issue of 14 pages,

making allowance for an advertising ratio of approximately 40 per cent.

Stating results in terms of total number of words reproduced and readership involved, it can be estimated that during the above period more than 47,000 words concerning Connecticut medicine were published in the state's newspapers, reaching at least 75 per cent of more than 568,000 paid subscribers.

### b. RADIO

Although no radio programs have been inaugurated, the subject is one receiving study. Investigation has shown that the problem in Connecticut cannot be solved as readily as in less populous states. The density of population in the Connecticut-New York area, and the consequent value of this audience to advertisers, has created one of the country's most competitive radio regions. Concentration of the powerful stations in New York City poses a problem difficult to cope with if an effective Connecticut program is to be planned. These stations consistently compete for the listener's attention with signals of stronger intensity than most of our local broadcasting facilities.

Despite this fact, it is felt an informative program on health and medical care can be developed through accent on purely local interests. It does not seem wise at this time to attempt formulation of any program aimed toward mass appeal. This would require dramatization, rehearsals, and script writing which would result in considerable cost. Since even the most modest program cannot be developed without some expenditure, the possibility of sponsorship which would not be injurious to the profession is now receiving attention.

### c. OTHER PUBLICATIONS

During the period, releases and special articles were written for the following publications: *Journal of the American Medical Association*, 29 releases; *CONNECTICUT STATE MEDICAL JOURNAL*, 27 releases and special articles; *Connecticut Pharmacist*, 7 special articles; *Reemployment* (monthly publication of the Connecticut Veterans Reemployment and Advisory Commission) full-page article concerning veterans' medical care.

### d. SPEAKERS BUREAU

Services of the bureau, organized last August, have been increasingly sought by organizations planning their 1947 programs. The only promotion used has been the mailing of a booklet outlining the service to organizations throughout the state. A total of 35 engagements have been arranged, the large majority for Parent-Teacher Associations. A number of talks have also been given before various groups by physicians through direct arrangement, but no accurate figure can be given on these since the office has received notification only in a few instances.

It is indicated that the bureau is meeting a definite need and that its services will be requested on a larger scale in the future. Its further promotion is being planned.

### e. DIRECT MAIL

This communications device has been used to keep in contact with newspaper editors through periodic mailing of news releases and editorial information. It has also been employed to promote the veterans' home-town medical care program.



## III. COOPERATION WITH OTHER ORGANIZATIONS

## a. VETERANS ADMINISTRATION

A cooperative public relations program was inaugurated with the Veterans Administration last December for the purpose of promoting the home-town plan for medical care of war veterans. This plan includes the maintenance of favorable public opinion and continuing support of the program by the public at large, veteran groups, the medical profession, pharmacists, civic leaders, and newspaper editors.

## b. CONNECTICUT REHABILITATION ASSOCIATION

This organization was formed in Hartford last October for the purpose of stimulating programs of guidance, physical restoration, training and job placement for disabled persons. Shortly after the association was formed, the State Medical Society was requested to aid in its promotion. Accordingly, publicity for the first program meeting of the organization was managed by the Society's public relations section and cooperation with the association is continuing.

## c. CONNECTICUT PHARMACEUTICAL ASSOCIATION

In addition to the articles which are written each month for the *Connecticut Pharmacist*, cooperation with this organization has been developed principally in the field of veterans' medical care. Several conferences with officers of the association have been held to extend this cooperative interest with the State Medical Society.

## d. CONNECTICUT CANCER SOCIETY

Assistance has been given in promoting the organization and operation of tumor clinics and close coordination with the headquarters of the Cancer Society has been established. A number of joint promotional projects which have been discussed will be put into operation as favorable conditions arise.

## e. NEW DEVELOPMENTS

The expansion of relationships with other groups has resulted recently in discussing future programs with the Manufacturers' Association of Connecticut; Newington Home for Crippled Children; Connecticut Society for Mental Hygiene; and the Connecticut Society for Crippled Children and Adults.

## IV. NEW PROJECTS

A proposal to inaugurate a health column as a service for weekly newspapers was recently submitted to the Public Health Committee for consideration and a similar column, designed to reach employee groups through industrial house organs, has been proposed to the Industrial Health Committee. The latter committee has approved a series of conferences with industrial managers concerning employee health problems. The general aim of the program is to increase the interest of management officials in matters of industrial health. The first conference in this series is now being planned.

An information service for newspaper editors, started last January, has met with considerable success and has resulted in the publication of a number of newspaper editorials favorable to the profession.

Respectfully submitted,  
James G. Burch

REPORT OF THE COMMITTEE ON  
TUMOR STUDY

Philip G. McLellan, *Chairman*

Robert R. Agnew	Kenneth K. Kinney
Irving B. Akerson	Averill A. Liebow
John D. Booth	Gustaf E. Lindskog
Donald A. Bristol	John A. McCreery
Willard A. Buckley	Christie McLeod
Joseph O. Collins	William Mendelsohn
A. Nowell Creadick	Lincoln Oppen
Thomas J. Danaher	Edward J. Ottenheimer
Edward W. Foster	Berkley M. Parmalee
Carl C. Harvey	Karl T. Phillips
Louis P. Hastings	Douglas J. Roberts
Joseph H. Howard	E. Myles Standish
Russell A. Keddy	Herbert Thoms
Ralph E. Kendall	State Commissioner of Health

Three meetings of the committee on Tumor Study were held during the year. The executive committee has had frequent meetings. Routine business has been carried on by various sub committees. The wisdom of having established autonomy to the component parts of the groups engaged in the state tumor program has become apparent as the program in the state has grown.

The Connecticut Cancer Society has enjoyed a remarkable growth under the masterful guidance of A. Nowell Creadick who has served as president since his election June 26, 1944. Edward J. Ottenheimer as Vice-president, Drs. Alfred L. Burgdorf, Ralph E. Kendall, Stanley H. Osborne, Creighton Barker, and Philip G. McLellan have served on the Executive Committee of the Society which meets each month. During the 1946 campaign approximately \$300,000 was raised in the state of which 60 per cent remained in Connecticut for various cancer projects. The judicious analysis and approval of projects for which this considerable amount of money should be spent has placed a great burden of responsibility upon the Medical Advisory Committee. Too much credit cannot be given to the members of this important committee for the time, effort, and wise council they have given. This committee has served very actively since it was formed in 1945 and was re-elected at the annual meeting of the committee on tumor study, June 4, 1946.

Alfred L. Burgdorf, Hartford, *Chairman*  
Wilmar M. Allen, Hartford  
Howard S. Colwell, New Haven  
William U. Gardiner, New Haven  
Joseph I. Linde, New Haven  
George M. Smith, New Haven  
Donald B. Wells, Hartford

The Connecticut Cancer Society has been very generous in its grants to further the tumor program in Connecticut. Through their efforts and support cancer research and many clinical programs have been subsidized. To mention but a few important projects that have had financial support of the society would include (1) over \$50,000.00 for cancer research (2) Financing cancer detection clinics (3) Paying the salary of the executive secretary of the Association of Connecticut Tumor Clinics (4) Supporting financially the color plates for a new handbook on cancer for the State Dental Association (5) Financial cooperation in developing the cancer sta-

tistics accumulated in the Cancer Research Division of the State Department of Health. The Medical Advisory Committee assigned the development of plans for cancer detection clinics to Drs. Howard S. Colwell and Donald B. Wells. On an experimental basis such clinics are now operating in New Haven, Hartford, and Meriden, with a fourth such clinic planned for Bridgeport in the near future.

With the return of the many physicians from the service it has been possible to reactivate and enlarge the program for the Association of Connecticut Tumor Clinics. This was felt essential to develop our educational program as well as to stimulate interest in the better care of cancer patients throughout the state. Excellent progress has been made under the chairmanship of Edward J. Ottenheimer. Dr. N. William Wawro, who has served as part time executive secretary, has been of great service in this development.

#### REPORT OF THE EXECUTIVE SECRETARY OF THE ASSOCIATION OF TUMOR CLINICS

The professional survey of all the state tumor clinics in the winter of 1945-46 revealed deficiencies which promoted the Association of Tumor Clinics to engage the services of a part time physician to visit each clinic at regular intervals in the capacity of observer and liaison agent. Such a plan is now approaching the completion of its ninth month of continuous function, and a progress note on this program will serve as an index of the activity of the Association of Tumor Clinics in the past year. Three outstanding developments have been noted:

(1) Whereas there were but 13 tumor clinics of varying quality in this state one year ago, as of April 1, 1947, there are 20 clinics which are organized to render this community service. Inherent in this expansion has been improvement in the quality of tumor records submitted to the state registry and also closer and more careful follow-up of previously treated cancer cases.

(2) The fall and winter meetings of the Association of Tumor Clinics at the Norwalk and Waterbury Hospitals respectively, averaged about 100 physicians, an expression of a new high in the activity of the Association.

(3) Inter-clinic visits, financed by a federal grant, have made possible a more personal contact by physicians of activities of their colleagues in various parts of the state. These trips have pointed out schemes of organization which have helped in the function of already existing clinics, but more important, have served as a medium for personal exchange of ideas.

It should be noted that at all times there has been close cooperation with the Committee on Tumor Study, the Medical Advisory Committee, Executive Committee of the Association of Tumor Clinics, and the Division of Research of the State Department of Health. The help of these four agencies has continued to nourish the enthusiasm of those responsible for the continued function of the member clinics in the Association.

Respectfully submitted,  
N. William Wawro

The State Department of Health in addition to its education contributions in published papers and pamphlets serves

an increasingly important place in the state cancer program. Funds from the United States Public Health Service have been made available through this department for educational work in cancer. The program is arranged to make it possible for three physicians from each hospital in the state to make four visits annually to some other Connecticut hospital and there attend a session of the tumor clinic. The objectives of the program are to enable the physicians serving on hospital staffs to become acquainted with the methods of operating tumor clinics and treating cancer throughout all parts of the state and by so doing to bring about a mutual exchange of information. The State Department of Health is publishing "*Cancer—A Handbook For The Physician*", the contents of which were revised by the scientific committee last year. Its delay in appearance has been due to the paper shortage. The department is also contributing to the dental handbook on cancer, which the State Dental Association is preparing under the Chairmanship of Wilbur D. Johnston, D.D.S., M.D., of New Haven. This handbook towards the completion of which the Dental Association has voted \$1,200.00, has the enthusiastic support of the Committee on Tumor Study and the Connecticut Cancer Society. It has become increasingly apparent that the mass of statistics on cancer that have been accumulated in the Division of Cancer Research of the State Department of Health represents a great wealth of data on cancer which is not available elsewhere and is a testimonial to the cooperation between the physicians and hospitals in the state and the State Department in obtaining and classifying these records. The more complete utilization of these records represents a project which has been studied intensively with the result that the project has been given to the scientific committee for development in conjunction with the State Department of Health. The report of the scientific committee incorporates these plans.

#### REPORT OF THE SCIENTIFIC COMMITTEE

The primary purpose of the Scientific Committee, namely the establishment and expansion of the tumor clinics throughout the state, has during the past year been largely taken over by the activity of the Association of Tumor Clinics through the executive secretary, Dr. Wawro. Consequently, this committee has held no formal meeting and this phase of the cancer program will be included in the report from the Association.

Under the stimulus of the American Cancer Society, the Scientific Committee has been assigned the task of accumulating, publishing, and developing the mass of statistics accruing over the past years under the direction of the Division of Cancer Research of the State Department of Health in cooperation with the tumor clinics in the state. A working program has been developed which embraces three general principles directed towards utilizing more fully the organization that has so far been developed. An authorization has been approved by the Committee on Tumor Study for enlarging the present Scientific Committee, whose duty it will be to council with the Division of Cancer Research in furthering this program in three phases, namely:

(1) To plan a uniform method of releasing data already available in the records with the Division of Cancer Research.

(2) To correct and to expand the forms for reporting cancer cases.

(3) To encourage and supervise special studies in selected groups of cancer. This ambitious study will require not only



a great amount of work but also the greatest cooperation from all interested in the Connecticut cancer program.

Respectfully submitted,  
Ralph E. Kendall

During the present year only a start has been made on several large projects. The Cancer Detection Clinics must be evaluated; The Association of Tumor Clinics must continue to improve and expand; the statistical data in the Cancer Research Division must be made widely available. The whole hearted cooperation between the physicians of the state, and the State Department of Health, with the financial and stimulating support of the Connecticut Cancer Society should hold much promise for the future.

Respectfully submitted,  
Philip G. McLellan

COMMITTEE ON HONORARY MEMBERS  
AND DEGREES

George M. Smith, *Chairman*

H. Gildersleeve Jarvis                      Joseph H. Howard

I have the honor to present the report of the Committee on Honorary Members and Degrees of the Connecticut State Medical Society.

Your Committee has carefully considered the matter of the bestowal of honorary memberships and degrees. It is the opinion of your Committee that no honorary members or degrees be recommended during the coming year.

Respectfully submitted,  
George M. Smith

REPORT OF BOARD OF TRUSTEES OF THE  
BUILDING FUND

James D. Gold, *Chairman*

C. Charles Burlingame                      George M. Smith  
Ralph W. Nichols                              Daniel Sullivan

Mr. President and Gentlemen of the House of Delegates:

The House of Delegates of this Society at its Annual Meeting in May 1943 directed the Council to appoint a Board of Trustees of the Society's Building Fund to consist of five members. The purposes of this Board were to "formulate plans and means whereby the Society may ultimately acquire by construction or purchase a building suitable for its use as office headquarters." Since that time the Board has endeavored to carry out the directions of the House of Delegates and its activities have consisted of solicitation of funds, the purchase of a site for the building and preliminary steps in the planning of such a building.

Changes in membership on the Board have occurred since it was first appointed in 1943. Dr. Roy Leak of Hartford resigned and was replaced by Dr. Ralph Nichols of New Haven. Lately Dr. Daniel Sullivan resigned because of ill health and

at the time of the writing of this report a successor for Dr. Sullivan had not been named but the Board has made a recommendation to the Council.

Encouraging progress has been made with the accumulation of funds necessary for our building, but additional efforts and contributions will be required. As of April 1, 1947, the Building Fund stood as follows:

Total Amount Pledged ..... \$65,894.00  
Total Amount Paid ..... 51,992.00

Total Number of Contributors divided as follows:

County	Number of Contributors	Per cent	Amount Contributed
Fairfield	232	45.4	\$14,699.00
Hartford	303	45.8	17,227.00
Litchfield	39	42.4	3,035.00
Middlesex	39	48.8	1,895.00
New Haven	260	38.7	19,661.00
New London	58	45.3	5,420.00
Tolland	7	36.8	430.00
Windham	21	46.7	1,437.00
Total	959	43.3	\$63,804.00
Special Gifts	5		2,090.00
Grand Total			\$65,894.00

It is noted that slightly less than one-half of the members of the Society have participated. There have been withdrawals from the Fund in the amount of \$12,000 for the outright purchase of a highly desirable site for the building and of \$1,419.30 in payment of a portion of the architects' fee. There is at present cash on hand of \$39,869.55 and unpaid pledges not yet due of \$13,902.

Conditions in the building trades have not improved and the cost of building is still very high but the Board of Trustees is of the opinion that each step leading toward the beginning of construction of our building should be taken without delay.

The Board believes that the interest of the Society will be served if the number of members of the Board is increased from five to ten so that it will be possible to divide the functions of the Board among three sub-committees. The functions of the sub-committees will be:

- (1) To continue solicitation of contributions from individual members.
- (2) To plan and develop a program of memorial contributions.
- (3) To work in close consultation with our architects in further planning, preparation of specifications and construction of the building.

To this end, the Board of Trustees of the Building Fund recommends to the House of Delegates that the resolution passed by the House of Delegates at its Annual Meeting on May 25, 1943, be amended so that the Board shall consist of ten members instead of five, two to be appointed each year by the Council and to serve over-lapping terms of five years. Mr. President, I move the acceptance of this report and the adoption of the recommendation.

Respectfully submitted,  
James D. Gold

## REPORT OF THE COMMITTEE ON COOPERATION WITH THE YALE MEDICAL SCHOOL

Thomas P. Murdock, *Chairman*

Charles J. Bartlett  
Edmund L. Douglass

James R. Miller  
Herbert Thoms

Mr. President and Gentlemen of the House of Delegates:

I have the very great pleasure to report that the Committee on Cooperation with Yale Medical School has been reactivated and held its first meeting in several years on November 19, 1946.

The Medical School was represented by Drs. F. G. Blake, G. B. Darling, S. C. Harvey, C. N. H. Long, J. R. Paul, and H. M. Wilson. Your Society was represented by Drs. C. J. Bartlett, Herbert Thoms, C. B. Gibson, and T. P. Murdock.

The agenda covered the following subjects: (1) Discussion as to the necessity of a second medical school in Connecticut. (2) The question of increasing enrollment at Yale University Medical School. (3) Department of Industrial Health at Yale Medical School. (4) Discussion of a graduate school. (5) The position of Yale Medical School in Relation to Federalized Medicine. (6) How can the Connecticut State Medical Society aid the Yale University Medical School?

All of these subjects were discussed at great length. It was the feeling of all that with the spirit of cooperation shown by the committees from the Medical School and the State Society much would be accomplished.

The representatives of the Medical School seemed anxious to do all in their power to solve not only the problems on the agenda but to aid Connecticut medicine in every way possible. The committee from the State Society felt that a most auspicious beginning had been made and that future meetings which are planned will be productive of great good.

Respectfully submitted,  
T. P. Murdock

## REPORT OF THE COMMITTEE TO STUDY THE ORGANIZATION AND OBJECTIVES OF THE CONNECTICUT STATE MEDICAL SOCIETY

Acting upon a resolution introduced by the Executive Secretary, the House of Delegates of the Connecticut State Medical Society voted at its Semi-Annual Meeting on December 21, 1946, that the President of the Society be authorized to appoint a committee, consisting of the eight elected councilors and one additional member from each county, to study the organization and objectives of the Society.

In compliance with these directions, the President appointed the following committee:

Courtney C. Bishop, New Haven, *Chairman*  
Samuel F. Mullins, Fairfield  
Oliver L. Stringfield, Fairfield  
D. C. Y. Moore, Hartford  
Arthur B. Landry, Hartford  
Floyd A. Weed, Litchfield  
Thomas J. Danaher, Litchfield  
Harold A. Speight, Middlesex

Frank H. Couch, Middlesex  
Herbert Thoms, New Haven  
George C. Gildersleeve, New London  
Charles G. Barnum, New London  
Charles T. Lamoure, Tolland  
William Schneider, Tolland  
Karl T. Phillips, Windham  
William M. Shepard, Windham

The first meeting of the Committee was held at the graduate's Club in New Haven on February 19, 1947 and was devoted entirely to a general discussion by the President of the Society of certain general objectives for the Committee's action.

A second meeting was held at the Graduate's Club on March 7, 1947 at which the Committee were the guests of the Council of the State Society. The meeting was devoted, with considerable success, to a mutual discussion with the Council and its officers, of certain of the basic problems to be dealt with by the Committee and to the development of an organizational plan for the future activities of the Committee. A Steering Committee was appointed, to consist of:

Arthur B. Landry, *Chairman*  
Oliver Stringfield  
Herbert Thoms

The enthusiasm of the Committee as a whole, its declaration of the necessity for monthly meetings, and the breadth of point of view in respect to the problems at hand, suggest that the study of the Committee of Sixteen may well prove valuable and far reaching.

Respectfully submitted,  
Courtney C. Bishop

## REPORT OF THE COMMITTEE ON MEDICAL CARE OF VETERANS

Samuel B. Rentsch, *Chairman*

Egbert M. Andrews  
Norton Canfield  
Joseph N. D'Esopo

Appointment of the present committee was authorized by the Council last spring, and the first meeting of committee members was held in New Haven on March 14, 1946.

Subsequent meetings have been held at approximately monthly intervals, augmented by several conferences with officials of the Veterans Administration.

In the early stages of formulating the plan for medical care of our veterans both Dr. Canfield and myself visited the headquarters of the Veterans Administration in Washington. A certain amount of red-tape slowed down our initial activities, as did also changes in top personnel at the regional office of the Veterans Administration in Hartford. However, though progress at times was tedious, these handicaps were finally surmounted. By the latter part of June committee members had completed the drafting of the plan and fee tables, and these were then forwarded to Washington for consideration.

Then a long period of waiting followed, and for a considerable time it appeared that all of our efforts had been of little avail. But on July 29th, Dr. Winthrop Adams, director of medical services at the administration's Boston offices, visited



with our committee in New Haven, and this was a welcome indication to us that, although speed was not on our side, the plan was actually in process. Finally, on October 15, 1946, the plan and Part I of the fee table were formally drawn up and signed as the substance of an agreement between the State Medical Society and the Veterans Administration.

Progress since then, as most of you know, has been more rapid. The plan was organized for promotion among veterans, physicians, and the general public, and the first newspaper publicity was released on November 25 through the Society's public relations section. Promotion of the plan among members of the Society was then conducted through the *CONNECTICUT STATE MEDICAL JOURNAL* and by direct mail. The mail campaign was undertaken jointly with the administration, and the regional office in Hartford furnished the mechanical facilities for this endeavor.

The cooperation of Connecticut physicians in joining the plan has been most encouraging. When the program was launched last November, 621 of the approximately 2600 physicians in the state were enrolled with the Veterans Administration. As of March 1st of this year the total numbered 1151 physicians. At first applications for fee-basis appointment flooded the Hartford office at rates as high as 60 per day. Now this has declined to approximately 15 per week, and this rate is continuing quite steadily.

Recently the Council requested our committee to continue to function in supervising operating procedures of the plan and to establish a board of review to adjust complaints if this is later thought to be necessary or advisable.

Thus authorized, the committee recently held a conference with representatives of the Hartford regional office of the Veterans Administration and representatives from the Connecticut Pharmaceutical Association to more closely coordinate our plan with the plan for veterans' prescription services which the pharmacists have recently undertaken. Further cooperation in this direction is planned.

Another matter which the committee is now completing concerns the adjustment and resubmission of fee tables for Part II and Part III of the present plan. Although these were prepared and forwarded with the plan when it was originally submitted, only Part I of the fee table was approved. It was explained by administration officials at that time that this procedure was advisable so that operation of the program would not be further delayed. We have recently been notified that the administration is now prepared to consider the additional fee tables, and we are accordingly making the necessary preparations.

Respectfully submitted,  
Samuel B. Rentsch

## REPORT OF THE COMMITTEE ON RURAL MEDICAL SERVICE

Norman H. Gardner, *Chairman*

David H. Bates

Gerst S. Gudernatch

William H. Upson

The Committee on Rural Health feels that the primary concern in our state should be the problem of educating the people who live in the rural areas as to what is meant by good

health facilities. There does not seem to be any real shortage of good medical personnel in Connecticut. Further, the rural population lives moderately close to an urban center. It is with this question in mind that we are planning our first Conference on Rural Health which we hope to hold at the University of Connecticut on July 16 of this year. We feel that the influence of those who speak at the conference will be felt throughout the state as those who attend make their reports to the groups who sent them. The people who attend such a meeting are in earnest. We hope we can nourish that interest to the end that there will be a definite improvement in rural health.

This committee alone cannot hope to carry out a program of better medical service to those living in outlying districts. It can only point the way and advise those who are interested, so they may build a better home situation for themselves. It must be pointed out here that the matter of improvement in the health of a community depends on many local factors peculiar to that particular community. Therefore, it is better to tackle the problem on a state or local level. For example, one town may need better facilities for the disposal of sewage, or better schools, or even better roads in order to attract a good physician to the area. No man is going to spend his time in a poor community, bring up his children in antiquated schools, and wrestle with makeshift simple conveniences when he can find a larger city which more nearly fills his needs. Another town may have all these but may lack a convenient center where the physician can avail himself of basic diagnostic needs.

The Second Annual Conference on Rural Health held in Chicago on Feb. 7 and 8 seemed to hold the promise of better cooperation among those interested in the subject. The National Grange, the American Farm Bureau Federation, the National Farmer's Union, as well as the medical profession were represented. The farmer is most interested in bettering his condition, and is determined to do so as quickly as possible. The majority wants to have some form of prepayment medical care on a voluntary basis. They are ready and willing to work out with us a satisfactory system which will take better care of their health needs. Some said that they had found opposition from the medical profession blocking their attempts at forming cooperative health plans. This causes some doubt as to our sincerity. Mr. Goss, National President of the Grange, said that the farmer is anxious to work with organized medicine to bring about good care for all, but that if we do not get together with them, they may naturally seek a federal system of medical care.

It was the opinion of the conference that the medical schools should be urged to get away from the idea of creating specialists, and concentrate more on turning out good general practitioners. The latter are more suited to rural practice. Some medical schools are even now sending their men into small hospitals for a short while as a means of showing them the advantages of rural practice.

The matter of state and community Health Councils received a great deal of attention at the Conference, these to consist of representatives from all groups interested in medical care and general health. It is felt that such a council would bring together all those who are in any way interested in health to the end that there would be less overlapping of func-

tions and consequently more efficient action in health matters. Vermont already has a Health Council on the state level which has in its membership even the two major labor unions. This seems to be working very well, but it is a little too soon to draw any conclusions.

If we are to have better rural health, all those interested must strive to work together as closely as possible, trying to forget the petty suspicions and jealousies which so often doom any effort to failure.

Respectfully submitted,  
Norman H. Gardner

### REPORT OF THE COMMITTEE ON DRUG ADDICTION

John H. Foster, *Chairman*

C. Charles Burlingame

Alfred Labensky

Arthur J. Jackson

Edgar C. Yerbury

Howard W. Haggard, *Associate Member*

There has been only one meeting of the Drug Addiction Committee this year—that was a combined meeting with the joint committee of the Connecticut Pharmaceutical Association and the State Medical Association where the question of introducing an amendment to the present Barbiturate law was discussed. From the evidence presented it was obvious that the barbiturates are still a real problem. In Connecticut there were fourteen deaths from barbiturates in 1945, and eleven in 1946, 10 suicide, —7 accidental.

Since the amendment in 1945 of the Connecticut State Law, barbiturates can now only be sold on prescription, and it is illegal to refill prescriptions for barbiturates without oral or written consent of the physician. This should prevent the purchase of barbiturates over the counter and help protect persons from becoming addicts and being poisoned by the drug. There are rumors that because of the increase in barbiturate addicts and actual deaths due to over dosage, and the tremendous amount of the drugs consumed annually, the Federal Narcotic Bureau will introduce a law similar to the Harrison Narcotic Law. This would involve so much record keeping on the part of the pharmacists and doctors and so much machinery for enforcement that one dreads to think of it.

The pharmacists report lack of cooperation from many of the physicians in carrying out the present law. Many doctors seem irritated when called by the pharmacists and say they do not want to be bothered and to go ahead and refill the prescription any number of times. This is illegal and defeats the object of the present law. We are sure most of the physicians welcome this check up of their patients on the part of the pharmacists and realize it is more trouble for the pharmacist than for the doctors. Common courtesy demands that we do our part in cooperating with them.

The Legal Department of the American Medical Association has drawn up a model law for the control of barbiturates, but it is very involved and does not seem to have any real advantage over our own Connecticut law, providing the doctors will continue to do their part.

The narcotic agents of the State Department of Health warn that the physicians are being too lax in filling out prop-

erly and completely the prescriptions for narcotics. Practice of telephoning in the narcotic prescriptions is illegal and is only permitted for emergencies and should be followed immediately by a written order. There are instances during the past year in which physicians' bags were stolen from their cars and rifled for narcotics. Doctors are asked to be careful not to leave their medical bags where they can be tampered.

We regret to note that Mr. Arthur J. Rivard who was the narcotic agent for the State Department of Health since the organization of the Narcotic Bureau in 1935 died June 10, 1946. He will be missed by all of the physicians of the state and especially by members of this committee. He set a standard for thoroughness and efficiency tempered with friendliness, courtesy and firmness that will be difficult for his successors to equal.

Respectfully submitted,  
John H. Foster

### REPORT OF THE JOINT CONFERENCE COMMITTEE WITH THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

William T. Salter, *Chairman*

Burdette J. Buck

Allan K. Poole

Barnett Greenhouse

Stanley B. Weld

During the war the operation of the Joint Committee representing the Connecticut Pharmaceutical Association and the Connecticut Medical Society had suspended its meetings. Reorganizing upon the request of the Connecticut Pharmaceutical Association, the Joint Committee (hereinafter referred to as JCC) met in Hartford on March 5, 1946 under the Chairmanship of Dr. Stanley B. Weld. Dr. Weld was Chairman of the 1941 Conference Committee.

It was agreed that the size of the Committee be limited to five members of each association with the President and Secretary of each association acting in an ex-officio capacity. Dr. Weld was named Chairman of the Committee and Mr. Louis Kazin was appointed Secretary. The Committee members included Sidney Curran, Paul Kunkel, Tracey Cadwell, Jack Malley, Miss Alice-Esther Garvin, Ralph Gentile, William T. Salter, M.D., John H. Foster, M.D., William J. H. Fischer, M.D., Barnett Greenhouse, M.D., Joseph H. Howard, M.D., and Creighton Barker, M.D. The State Medical Society appointed a new slate of members for its section of this Committee after its annual meeting. The present medical members are William T. Salter, M.D., Burdette J. Buck, M.D., Allan K. Poole, M.D., Barnett Greenhouse, M.D., Cole B. Gibson, M.D., and Creighton Barker, M.D. Dr. Salter was appointed as Chairman. The pharmacy slate remained the same.

As a basis for committee action, the 1941 Committee's set of principles and recommendations was placed on record. The fundamental principle of committee activity is one which stresses the fact that every problem or point brought before this committee must be of mutual concern, and is approached in the same manner.

#### MEETINGS

The Committee has agreed to meet at least four times a year, or at the discretion of the Chairman. Meetings were held in



Hartford, March 5, 1946, New Haven, April 23, 1946, Bridgeport, July 23, 1946, Waterbury, September 24, 1946, Hartford, December 5, 1946, and New Haven, March 5, 1947.

#### COUNTY ORGANIZATIONS

##### RESOLUTION ON COUNTY ORGANIZATION

"In order that information regarding policies, recommendations, and questions of procedure may be properly disseminated throughout the state, this Committee recommends that both State organizations set up Joint Committees in the eight counties of Connecticut, modeled along the lines of the State Committee. Where local committees exist, they will act in the capacity of sub-committee to the county organization."

County organizations have been requested to follow the pattern of the State JCC, and reports of all committee meetings are sent to all County Secretaries. At the present moment there are County JCCs functioning in Hartford and New Haven. The State JCC has requested that all publicity releases be made through the state office, and all material requested by county organizations will be placed at their disposal by the State organization.

During the County Medical meetings held in the fall of 1946, representatives of the State JCC spoke at these gatherings. Dr. Salter spoke at Windham County, Mr. Kazin spoke at New London, Mr. Cadwell spoke at Fairfield, and Dr. Weld spoke at New Haven.

#### RESOLUTIONS

The following resolutions have been endorsed by the State JCC:

1. "The use of prescription blanks bearing a pharmacist's name is bound to be misunderstood and has no justification whatever. We recommend that the Connecticut State Medical Society adopt a policy urging physicians to use blank prescription forms."

2. "It is a physician's responsibility to be certain that his prescriptions are filled accurately and competently. But this does not necessarily imply that a physician should direct his prescriptions be filled by a specific pharmacy. Experience and contacts often develop great confidence between physician and pharmacists but physicians should be most careful not to suggest that certain pharmacies are inferior to others. If repeated experience leads a physician to a conclusion that the compounding of prescriptions by some pharmacist is incompetent or undependable the Joint Conference Committee should provide a Committee to give dignified and unprejudiced consideration to such charges and their correction."

#### PUBLICITY

The State Journals of both associations have been requested to publicize the activities of all Joint Conference Committees. The opinion was also expressed that descriptive pieces of individual mailing should be sent at stated intervals to physicians and pharmacists in any given area. As has been stated, all publicity must be channeled through the state office and printed on the official stationery of the JCC.

#### LEGISLATION

In view of the national trend toward a model barbiturate law, the JCC concerned itself with this problem and presented what it considered practical barbiturate legislation for the

State of Connecticut to the respective Legislative Committees of both associations. After due consideration of both groups, the proposed legislation was tabled to await further developments.

#### COMPLAINTS

All members of both state organizations have been requested to report all complaints, grievances or irregularities to the State Office or the Secretary of either State Group. Where County JCCs are functioning, members are asked to present their grievances to these committees.

The State JCC concerned itself with several grievances during the past year, handling all such situations in a manner approved by all members. Complaints are channeled through the State Medical Society or the State Board of Pharmacy Commissioners, and all members are requested again to make use of this committee. All these matters are handled without publicity, and stress is placed upon correction, rather than prosecution.

#### EXPENSES

All expenses of the State JCC will be divided between both state associations, and Secretaries of the both organizations are billed by the State JCC.

#### NARCOTICS

The Committee is vitally concerned with the question of narcotics, and has placed this matter on the agenda at several meetings. This problem is becoming more serious as it affects pharmacists and physicians, and although the JCC has not completed its study of the Connecticut situation, all members are asked to refresh themselves as to rules and regulations under the Harrison Narcotic Law.

#### AMERICAN COUNCIL ON EDUCATION

Dr. Edward T. Elliott has requested a complete description of JCC activities for his American Council on Education. He feels that the pattern set forth by Connecticut should be adopted in other states.

#### COMMENT

As the Joint Committee is now organized it should be able to contribute towards a higher standard of therapeutics in Connecticut. The affiliated County Committees bring the central committee into contact with problems in all parts of the state. Moreover, the Committee frequently invites experts to join its discussions on such matters as barbiturate legislation. From such discussions it has become clear that the greatest need at present is for education, both for pharmacists and physicians. The Joint Committee has embarked upon such a program along two general lines. First, through addresses at meetings throughout the State it is able to call attention to problems of pressing interest. Secondly, as complaints of glaring infractions of professional ethics are reported in individual cases, it is able to discuss these problems quietly with the individuals concerned.

Respectfully submitted,  
William T. Salter

## REPORT OF THE COMMITTEE ON MILITARY HISTORY

Ralph L. Gilman, *Chairman*

Norton Canfield	Louis F. Middlebrook, Jr.
Clair B. Crampton	Ralph M. Tovell
James C. Fox	Ira V. Hiscock,

*Associate Member*

During the past year material has been slowly trickling in in response to our letter to all those who had been in military service. One formal meeting has been held on February 27, 1947 at the State office. At this meeting preliminary plans were laid for tabulating and summarizing the information contained in the questionnaires sent out to all members who had served in the armed forces. We also made preliminary plans for securing and utilizing further contributions from these men on their personal experiences. The work of this committee will of necessity have to extend over a considerable period of time, due partly to the nature of the project and partly to the fact that the members of the committee are extremely busy in their practice as are all the members of the society. For the slow progress to date we beg your indulgence.

Respectfully submitted,  
Ralph L. Gilman

Two meetings have been held since the formation of the committee, and the following objectives have been outlined:

1. Continued and more detailed study of maternal mortality.
2. A study of the present maternal mortality blank with the object of making changes to enhance its value.
3. Encourage hospitals to keep an accurate record of maternal morbidity and to standardize their definition of morbidity in the future.
4. A study of caesarian sections in various parts of the State.
5. Encourage meetings at regular intervals in various communities to discuss maternal deaths.
6. To inform physicians of the importance of properly completed death certificates in order that we may more accurately place the cause of death in its proper classification.

The Committee is also of the opinion that a uniform history blank to be used throughout the State should be of great value, and a sub-committee consisting of Doctors Peckham and Johnson were appointed to study this matter.

Our group will meet monthly to review all maternal deaths occurring during the previous month.

Respectfully submitted,  
Joseph H. Howard

## REPORT OF THE COMMITTEE ON HEALTH AND PHYSICAL EDUCATION

Joseph L. Hetzel, *Chairman*

Paul Harper	Robert P. Rogers
Derick January	James M. Sturtevant
Frank S. Jones	Carl L. Thenebe
Joseph I. Linde	Edward T. Wakeman
Katherine S. Quinn	Ira V. Hiscock,

*Associate Member*

There has been no real progress made by this committee since the last meeting.

Respectfully submitted,  
Joseph L. Hetzel

## REPORT OF THE ADVISORY COMMITTEE TO THE WOMAN'S AUXILIARY

Ralph L. Gilman, *Chairman*

John D. Booth	Alfred Labensky
Barnett Freedman	Harry F. Pennington
James D. Gold	E. Myles Standish

The committee has held only one formal meeting during the year, on August 28, 1946 at the State Society office in New Haven. This was called at the request of Mrs. Gold, the President of the Auxiliary. We suggested to the Auxiliary that they might concentrate on the following projects during the year:

1. Publicize the Speakers of the State Society to lay organizations.
2. Cooperate with Dr. Hetzel's committee on School Health.
3. Secure information for the Society's office regarding the views of legislators from towns and cities, especially concerning their attitudes toward medical and public health legislation.
4. Stimulate the formation of semi-formal groups of Auxiliary members in the larger towns and cities with the idea that such groups could promote the social side of the Auxiliary and serve to further mutual acquaintanceship of the local physicians and their families.

By mail the committee unanimously approved the project of the Hygeia Committee of the Auxiliary to work for the introduction of Hygeia into the health education program of the secondary schools.

Respectfully submitted,  
Ralph L. Gilman

## REPORT OF THE COMMITTEE ON MATERNAL MORTALITY AND MORBIDITY

Joseph H. Howard, *Chairman*

Eric H. Blank	Norman C. Margolius
Carl E. Johnson	Charles H. Peckham

The last meeting of the House of Delegates of the Connecticut State Medical Society directed the formation of a permanent committee on Maternal Mortality and Morbidity. This Committee consists of Joseph H. Howard, *Chairman*; Eric H. Blank, Carl E. Johnson, Charles H. Peckham, and Norman C. Margolius. Cooperation with the Childrens Bureau of the State Department of Health appeared essential for the proper functioning of the committee, and Dr. Elizabeth Wells, Child Hygiene Physician of the Health Department, and Mr. Edwin Tracy, Statistician, have been present at our meetings.



## REPORT OF THE DELEGATES TO THE COUNCIL OF NEW ENGLAND STATE MEDICAL SOCIETIES

Cole B. Gibson

Louis P. Hastings

C. Frederick Yeager

The Council of the New England State Medical Societies has just completed a year which has been productive of valuable cooperation and understanding between the six Societies. In April 1946, Dr. James R. Miller, who had given such splendid stimulation to the organization, was succeeded as President by Dr. C. R. Metcalf, of New Hampshire, and Mr. John E. Farrell, of Rhode Island, was continued in the post of Executive Secretary which he so ably fills.

Four important meetings have been held during the year, all attended by delegates from each of the New England States. As an indication of the fields of interest, the following is a partial list of the topics of discussion at these meetings: Health Education, Post War Hospital Planning, Group Practice, Medical Economics, Medical Legislation, Labor Relations, Post Graduate Planning, and Medical Licensure with particular reference to the development of reciprocal arrangements between the New England States.

In addition, the Executive Secretary provides an information service covering happenings of importance to medicine both at the national and local levels.

Consideration of these matters from a sectional viewpoint with our friends and neighbors from nearby states has proved to be a highly successful endeavor and results have been fruitful.

The Council should be supported by our interest and cooperation not only because it offers a medium for the exchange of information on mutual problems. It could well develop a solidarity of opinion and purpose that might profoundly affect the whole pattern of American medicine.

## REPORT OF COMMITTEE REPRESENTING CONNECTICUT STATE MEDICAL SOCIETY ON BOARD OF DIRECTORS OF CONNECTICUT HOSPITAL SERVICE, INC.

Arthur B. Landry, *Chairman*

William C. McGuire

Ralph T. Ogden

My induction as a member into the Board of Directors of the Connecticut Hospital Service, Inc. and my subsequent election to its executive committee came at the time when the organization was confronted with the necessity of adjusting the premium rates of the 560,000 Connecticut subscribers to the Blue Cross Plan.

As a freshman member, so to speak, on the Board of Directors your Chairman had to go through a rigorous apprenticeship at once exacting and educational in a brand new field. Only to a modest degree, then, has he contributed to the achievements of the Board. My attendance at all but two of the meetings of the executive committee has been very instructive and enlightening.

The new contract initiated last September with its adjusted rates to subscribers should make it possible for the Blue Cross to pay full costs of medical service rendered by the member hospitals, thereby obviating the discrepancies which caused some of the member hospitals to consider withdrawal from the Plan. Since then the organization has been raised from a status of precarious solvency to the present position of financial solidarity.

The proposal for the marketing by the Blue Cross of a Connecticut State Medical Society-sponsored cash indemnity prepaid surgical and obstetrical contract was considered at this time unwise. Furthermore, it was deemed inadvisable to take formal action on a proposition having as yet no legal status and lacking the approval of the Insurance Commissioner.

Your chairman believes that it is still possible for the Blue Cross and the Connecticut State Medical Society to join hands in establishing a model plan of prepaid medical care which would be enthusiastically accepted by the public, the medical profession and the Blue Cross authorities.

Respectfully submitted,

Arthur B. Landry

## REPORT OF THE BLOOD DONOR SERVICE COMMITTEE

Ralph E. Kendall, *Chairman*

Irving B. Akerson

Averill A. Liebow

Arthur J. Geiger

Karl T. Phillips

Donald B. Wells

The Blood Donor Service Committee wishes to make a report of their activities during the past year.

Our activities have been directed to stimulating and coordinating other agencies and groups interested in a blood donor service. The most important is the Connecticut chapters of the American Red Cross. Considerable stimulus has been given to the overall project by a recent directive issued by the National Red Cross permitting the chapters to participate actively not only on a voluntary basis, but also to assume a considerable measure of financial responsibilities. The committee has conferred with the State Department of Health and has received their support to act as a sponsoring agent for the project in cooperation with the Medical Society and the Red Cross chapters.

To this end there has been introduced into the present Legislative session a bill by Representative Edgerton, permitting the State Department of Health to act in this capacity and carrying with it necessary funds to activate the program. Your committee, in conjunction with other interested parties, has taken part in the support of this legislation.

In this complex problem, progress has at times appeared extremely slow, but it is the Committee's feeling that such an important activity should not be undertaken without the most careful consideration. There is no doubt that the general plan is well thought of by an increasing number of people throughout the country and many states are at present developing a comparable blood donor program.

Respectfully submitted,

Ralph E. Kendall





ing an unused balance of \$3,654.39 which has been reverted to surplus.

Annual meeting cash of \$5,988.17 was confirmed directly to us by the New Milford Savings Bank.

Gurdon W. Russell Fund:

Cash of \$2,860.01 in the Mechanics Savings Bank, Hartford, was confirmed by direct correspondence.

We examined the following securities held by this fund:

PAR VALUE	VALUE DECEMBER 31, 1946	
	PER BOOKS	MARKET
\$2,000 Consolidated Railway Company (N. H.) 4% debenture bonds, due July 1, 1954 .....	\$ 230.00	\$ 750.00
\$1,000 Boston and Albany Railroad Company, 4½% improvement bonds, due August 1, 1978 .....	820.00	970.00
\$5,000 U. S. Treasury bonds, 2¼% due 1959 .....	5,000.00	5,260.90
Totals .....	\$6,050.00	\$6,980.90

O. C. Smith Fund:

We confirmed the principal and income cash in the Mechanics Savings Bank, Hartford, by direct correspondence.

Clinical Congress:

Cash on hand of \$1.10 was counted and an amount of \$4,362.60 was confirmed directly to us by the New Haven Savings Bank.

Building Fund:

Cash in banks, which was confirmed directly with the depositories, is accounted for as follows:

Mechanics and Farmers Savings Bank of Bridgeport..	8,768.92
Milford Savings Bank .....	10,000.00
City Savings Bank of Bridgeport .....	8,215.23
Bridgeport Peoples Savings Bank .....	10,651.46
Total .....	\$37,635.61

We examined the warranty deed to property known as No. 325 Edwards Street, New Haven, which was purchased during the year. The cost of this property, as at December 31, 1946 is valued as follows:

Purchase price of land .....	\$12,000.00
Title search expense .....	160.31
Survey expense .....	110.00
Total .....	\$12,270.31

Other expenses of \$752.31 incidental to the building fund are included as general expenses.

In our opinion the accompanying balance sheet and related statements of income and current fund surplus present fairly the position of The Connecticut State Medical Society at December 31, 1946, and the results of its operations for the year then ended, in conformity with generally accepted accounting principles applied on a basis consistent with that of the preceding year.

Seward and Monde,  
Certified Public Accountants

New Haven, Connecticut  
March 28, 1947

Balance Sheet, December 31, 1946

CURRENT FUNDS

GENERAL

ASSETS

Cash .....	\$34,686.57
United States Treasury bonds (market value \$12,992.19) .....	12,500.00
Dues receivable—1946 .....	2,009.00
Accounts receivable—Journal advertising .....	1,169.30
Accounts receivable—other .....	62.19
Inventory—emblems (at cost) .....	219.58
Total .....	\$50,646.64

LIABILITIES

Accounts payable:	
Journal .....	\$ 105.86
County dues .....	64.00
Chairman of council .....	300.00
Accrued commissions—1946 dues .....	87.15
General fund surplus .....	50,089.63
Total .....	\$50,646.64
Cash—New Milford Savings Bank .....	\$ 5,988.17
Total current funds .....	\$56,634.81
Annual meeting surplus .....	\$ 5,988.17
Total current funds .....	\$56,634.81

SPECIAL FUNDS

Gurdon W. Russell Fund:	
Cash .....	\$ 2,860.01
Securities (market value \$6,980.90) .....	6,050.00
	\$ 8,910.01
O. C. Smith Trust Fund:	
Principal cash .....	\$ 1,006.25
Income cash .....	308.19
	1,314.44
Clinical Congress—cash .....	4,363.70
Building Fund:	
Cash .....	37,635.61
Land .....	12,270.31
Architect fees .....	1,419.30
	51,325.22
Total .....	\$ 65,913.37
Grand total .....	\$122,548.18
Gurdon W. Russell Fund—capital .....	\$ 8,910.01
O. C. Smith Trust Fund—capital .....	1,314.44
Clinical Congress—capital .....	4,363.70
Building Fund—capital .....	51,325.22
Total .....	\$ 65,913.37
Grand total .....	\$122,548.18

Statement of Current Funds Surplus  
Year Ended December 31, 1946

	TOTAL	GENERAL	EXECUTIVE SECRETARY	JOURNAL	COMMERCIAL EXHIBIT AND ANNUAL MEETING	PREPAID MEDICAL SURPLUS
Balance, January 1, 1946 .....	\$50,438.87	\$45,976.41			\$ 4,462.46	
Less, Adjustment of 1945 dues net of commissions .....	150.00	150.00				
	<u>\$50,288.87</u>	<u>\$45,826.41</u>			<u>\$ 4,462.46</u>	
Summary of 1946 transactions:						
Income .....		\$33,081.15		\$25,695.51	\$ 6,756.68	
Expenses .....		8,369.33	\$21,163.59	23,634.91	5,230.97	\$ 1,345.61
Excess of income over expenses .....	5,788.93	24,711.82	21,163.59	2,060.60	1,525.71	1,345.61
Allotment transfers .....		50,650.00	23,000.00	22,650.00		5,000.00
	<u>\$ 5,788.93</u>	<u>\$25,938.18</u>	<u>\$ 1,836.41</u>	<u>\$24,710.60</u>	<u>\$ 1,525.71</u>	<u>\$ 3,654.39</u>
Balance, December 31, 1946 before transfer of un- expended budget allotments .....	\$56,077.80	\$19,888.23	\$ 1,836.41	\$24,710.60	\$ 5,988.17	\$ 3,654.39
Transfer of unexpended budget allotments and journal earnings to general surplus .....		30,201.40	1,836.41	24,710.60		3,654.39
Balance, December 31, 1946 .....	<u>\$56,077.80</u>	<u>\$50,089.63</u>			<u>\$ 5,988.17</u>	

Statement of General Income  
Year ended December 31, 1946

Income:

Dues earned (net of estimated \$1,570.00 military exemptions) .....	\$33,785.82
Less, Commissions paid .....	1,382.69
	<u>\$32,403.13</u>
Interest on investments .....	678.02
Gross income .....	<u>\$33,081.15</u>

Rural health .....	164.03
Veterans advisory .....	259.99
Tumor .....	52.81
Military history .....	102.45
Miscellaneous .....	658.39
	<u>\$ 2,125.83</u>
Miscellaneous .....	23.71
	<u>\$ 8369.33</u>
Excess of income over expenses .....	<u>\$24,711.82</u>

Expenses:

Council .....	\$ 398.98
Chairman of council .....	300.00
Delegates—A.M.A. convention .....	1,329.58
Treasurer:	
Clerical services .....	\$ 600.00
Fiscal agent fee .....	150.00
Insurance .....	43.75
Professional fees .....	450.00
Postage .....	106.25
	<u>\$ 1,350.00</u>

Public relations:

Director .....	\$ 1,375.00
Travel .....	308.97
Printing and supplies .....	1,157.26
	<u>\$ 2,841.23</u>

Committees:

Trustees of building fund ....	\$ 752.31
National legislation .....	135.85

Statement of Executive Secretary's Expenses  
Year ended December 31, 1946

Secretary expense:

Salary .....	\$ 9,999.94
Travel .....	900.00
	<u>\$ 9,999.94</u>
Office salaries .....	8,570.78
Rent .....	1,020.00
Light .....	69.34
Telephone and telegraph .....	374.07
Printing and postage .....	505.66
Office supplies .....	220.97
Janitor .....	143.00
Bank charges .....	21.71
Insurance .....	32.10
Publications .....	73.85
Miscellaneous .....	132.17

Total .....	<u>\$21,163.59</u>
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Statement of Special Funds  
Year ended December 31, 1946

	TOTAL	GURDON W. RUSSELL FUND	O. C. SMITH TRUST FUND	CLINICAL CONGRESS	ANNA FULLER FUND	BUILDING FUND
Balance, January 1, 1946 .....	\$46,699.23	\$ 8,966.30	\$ 1,427.17	\$ 3,919.96	\$ 200.00	\$32,185.80
Add:						
Gifts .....	18,586.00					18,586.00
Interest on savings accounts .....	717.22	57.75	27.27	78.78		553.42
Interest on bonds .....	235.00	235.00				
Registrations and luncheon fees .....	2,144.45			2,144.45		
	<u>\$68,381.90</u>	<u>\$ 9,259.05</u>	<u>\$ 1,454.44</u>	<u>\$ 6,143.19</u>	<u>\$ 200.00</u>	<u>\$51,325.22</u>
Less, Expenses:						
Payments of members' dues .....	\$ 140.00		\$ 140.00			
Purchase of office equipment .....	349.04	\$ 349.04				
Lunches .....	231.40			\$ 231.40		
Programs and posters .....	235.25			235.25		
Services—stenographic and clerical .....	242.20			242.20		
Stationery and printing .....	158.00			158.00		
Travel—speakers .....	236.53			236.53		
Entertainment—speakers .....	229.47			229.47		
Reception .....	150.00			150.00		
Rental of sound equipment .....	68.00			68.00		
Telephone .....	35.02			35.02		
Bank charges .....	10.21			10.21		
Rent of hall .....	100.00			100.00		
Chairman expense .....	29.76			29.76		
Badges .....	30.25			30.25		
Miscellaneous .....	23.40			23.40		
Survey of Tumor clinics .....	200.00				\$ 200.00	
Totals .....	<u>\$ 2,468.53</u>	<u>\$ 349.04</u>	<u>\$ 140.00</u>	<u>\$ 1,779.49</u>	<u>\$ 200.00</u>	
Balance, December 31, 1946 .....	<u>\$65,913.37</u>	<u>\$ 8,910.01</u>	<u>\$ 1,314.44</u>	<u>\$ 4,363.70</u>		<u>\$51,325.22</u>

Statement of Journal Income  
Year ended December 31, 1946

## Income:

Advertising (net of commissions of \$4,204.99) .....	\$23,936.55
Subscriptions .....	442.50
Reprints .....	919.74
Electrotypes .....	198.52
Single copy .....	39.08
Miscellaneous .....	159.12
	<u>\$25,695.51</u>

Postage and handling .....	685.13
Electrotypes .....	400.26
Reprints .....	772.61
Editor's salaries .....	3,999.84
Office salaries .....	3,088.64
Office expense .....	535.77
Rent .....	855.00
Telephone .....	85.11
Editorial board and meeting expense .....	276.49
Copyrights .....	24.00
Taxes .....	11.20
Bonding and insurance .....	22.22
Miscellaneous .....	68.63
	<u>23,634.91</u>

## Expenses:

Printing .....	12,810.01
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Excess of income over expenses .....\$ 2,060.60

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. JAMES DOUGLAS GOLD, Bridgeport*      *Recording Secretary, Mrs. CHARLES W. GOFF, West Hartford*  
*President-Elect, Mrs. ALFRED LABENSKY, New London*      *Corresponding Secretary, Mrs. EDWIN R. CONNORS, Bridgeport*  
*First Vice-President, Mrs. FREDERIC W. WERSEBE, Washington*      *Treasurer, Mrs. FRANK DiSTASIO, New Haven*  
*Second Vice-President, Mrs. JAMES RAGLAN MILLER, Hartford*

**LAST CALL** for reservations for the Twenty-fourth Annual Convention of the Woman's Auxiliary to the American Medical Association, which will be held at Haddon Hall Hotel, Atlantic City, New Jersey

### ATLANTIC CITY EXTENDS A HEARTY WELCOME TO YOU

The regular monthly meeting of the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society was held at "Corner House," Farmington, on Wednesday, March 26. Luncheon was served at 12:30 P. M., followed by a business meeting. Mrs. James Douglas Gold, president, presided and heard reports of the officers and standing committee chairmen. Mrs. Robert J. Cook, chairman of the Legislation Committee discussed House bills presented to this legislature. She emphasized the importance of opposing the bill which concerns the establishment and administration of a state system of health insurance and supporting all health bills for the aged and chronically ill.

#### Fairfield County

The Board of Directors of the Fairfield County Woman's Auxiliary met for luncheon and a business meeting at the home of the President, Mrs. Harold Amos, Deerfield Drive, Greenwich, on March 24. Mrs. Harold L. Weber, program chairman, announced that the annual County meeting would be held on April 21 at the Housatonic Lodge, Stratford, with luncheon at 12:30 P. M., followed by a short business meeting and program. Mrs. Ruth Kenzie, head of the Department of Occupational Therapy and Rehabilitation at Laurel Heights Sanatorium, will be the guest speaker.

#### Hartford County

The annual meeting of the Woman's Auxiliary to the Hartford County Medical Association was held on April 1, at the Hartford Golf Club, Hartford. The following new officers were elected: Mrs. Paul

W. Tisher, president; Mrs. Ralph T. Ogden, president-elect; Mrs. J. Whitfield Larrabee, first vice-president; Mrs. Louis Gold, second vice-president; Mrs. Harvey B. Goddard, corresponding secretary;



Mrs. JAMES DOUGLAS GOLD  
Retiring President

Mrs. Edwin C. Higgins, recording secretary; Mrs. James R. Cullen, treasurer.

Mrs. J. Douglas Gold, president of the Woman's



Auxiliary to the Connecticut State Medical Society, spoke briefly. After dinner the speaker for the evening, Mrs. Owen T. Rumsey of New Britain, chose as her subject "The Modern Woman—Is She Worth Her Keep?" Mrs. Rumsey gave some interesting excerpts from her new book which is to be published by Bobbs-Merrill Publishing Company. The members present enjoyed the interesting comparisons between the modern woman and her predecessors.

Mrs. Nicholas A. Marinaro, Newington, has designed the pin to be presented yearly to the outgoing president of the Woman's Auxiliary to the Hartford County Medical Association.

Litchfield County

The Litchfield County Woman's Auxiliary held their annual Spring meeting at the home of their President, Mrs. Frank L. Polito, Highland Lake, on April 15. Grace Mooney, PH.D., of New Haven was the guest speaker.

Middlesex County

Mrs. Walter N. Nelson, president of the Woman's Auxiliary to the Middlesex County Medical Association, entertained the executive committee members of the organization at her home in Cromwell on Thursday, March 6. A delicious luncheon was served and decorations were bouquets of early spring flowers.

The following officers and chairmen of committees were present: Mrs. G. Mansfield Craig, Mrs. Lloyd Minor, Mrs. Charles Russman, Mrs. Philip Schwartz, Mrs. Louis Soreff, Mrs. Frederick Tracy, Mrs. William Wrang and Mrs. Edgar C. Yerbury.

The annual spring meeting of the Middlesex County Woman's Auxiliary was held on April 24 at the Edgewood Country Club, Cromwell. Mrs. Paul S. Phelps, president of the Hartford County Woman's Auxiliary, was the guest speaker.

New Haven County

The annual meeting of the New Haven County Woman's Auxiliary was held on March 27 at the Oakdale Tavern in Wallingford at 12:30 P. M. Fifty-seven members were present. Mrs. Creighton Barker, president, reported for her committees. Mrs. Barnett Freedman, chairman of the Nominating Committee, presented the slate of officers which

was passed. President, Mrs. Harry Pennington, Meriden; Vice-President, Mrs. Lewis Foster, New Haven; President-elect, Mrs. Arthur Morse, New Haven; Corresponding Secretary, Mrs. George Fox, Meriden; Recording Secretary, Mrs. Paul Vestal, New Haven.

Mrs. James Douglas Gold brought greetings from the State Auxiliary. The guest speaker, Miss Virginia Parsons of the National Tuberculosis Association, spoke on "New Methods of Health Education."

Members of the Meriden Auxiliary were hostesses with Mrs. George Fox and Mrs. Harry Pennington in charge of the arrangements.

New London County

The New London Woman's Auxiliary held their annual Spring meeting at Edgemere Manor, Stonington, on Wednesday, April 9, at 12:30 P. M. Mrs. Walter Lukoski, chairman of the Nominating Committee, presented the new slate of officers. Mrs. James Douglas Gold, Mrs. Creighton Barker, and Dr. Creighton Barker were the guests of honor. Dr. Morris Fishbein, editor of the *American Medical Journal*, was the guest speaker.

NEW LONDON COUNTY AGAIN EXCEEDS ITS HYGEIA QUOTA

The following is a table showing the quotas and the number of *Hygeia* achievement points in the various Counties of the State for 1945-46 and 1946-47:

COUNTY	NO. OF ACHIEVEMENT		NO. OF ACHIEVEMENT	
	QUOTA	POINTS	QUOTA	POINTS
	1945-46	1945-46	1946-47	1946-47
New London	47	73	55	100
Hartford	126	107	137	66
New Haven	175	0	181	91
Fairfield	78	0	90	3
Windham	18	0	21	2
Middlesex	43	0	38	14
Litchfield	18	0	37	0

The table shows a 53 per cent increase in placements of *Hygeia* throughout the State. An encouraging factor is that this year six counties were active in securing these subscriptions as compared to two counties last year. Every member of the Auxiliary should be aware of the fact that the objective of the Woman's Auxiliary to the American Medical Asso-

ciation is health education, with *Hygeia* as one of the primary mediums of such endeavor.

Mrs. Dewey Katz, State *Hygeia* Chairman

### Windham County

The Windham County Woman's Auxiliary held an executive meeting at the home of Mrs. Andrew Laakso in Danielson on March 25. The annual spring meeting was scheduled for April 17 at the Nathan Hale Hotel in Willimantic. Dr. R. H. Guthrie of the Norwich State Hospital spoke on Psychiatric Trends of the Present Day.

### Amanda Pierson Russell 1868 - 1946

Mrs. Amanda (Pierson) Russell, wife of Dr. John J. Russell of Main Street, Putnam, a member of the Woman's Auxiliary to the Windham County Medical Association, died on November 3, 1946 at her home. She was born in Johnstown, N. Y., on July 31, 1868.

Mrs. Russell has been a prominent resident of Putnam for the past 53 years. She was a member of the Congregational Church and was active in the affairs of the church. She was also a member of the Elizabeth Porter Putnam Chapter, Daughters of the American Revolution, and the Putnam Woman's Club.

Mrs. Russell was interested in all community affairs, had many friends and was of a very generous nature, always ready to help and anxious to go the "second mile."

Besides her husband, oldest practising physician in the community, she leaves two daughters, Elizabeth, a laboratory technician at the Worcester City Hospital until her mother's last illness, and Mrs. John H. Moss of Providence, R. I., a brother Charles Pierson of Johnstown, N. Y., and a grandchild, John Russell Moss, student at Dartmouth College.

Funeral services were held from her home on Wednesday, November 6, in charge of Rev. Henry Robinson. Burial was in the Grove Street cemetery in Putnam.

### Student Nurse Enrollment Program

An intensified student nurse enrollment program will be conducted on a nationwide scale by the American Hospital Association throughout 1947, it

was announced recently by John H. Hayes, Association president.

In an effort to overcome the acute shortage of nurses, the Association plans direct aids to hospital schools of nursing with a backdrop of national publicity, Mr. Hayes said. The Association's Board of Trustees voted an expenditure of \$10,000 for this campaign, and hospital schools of nursing and other organizations affected by the shortage of nurses are being asked to contribute financial help.

The Association staff will offer consultation services as a way of exchanging practical ideas for nurse recruitment, including outlines for speeches and methods of approach for high school recruiting, organizing recruitment in cities having more than one school of nursing, enlisting support of civic groups, establishment of scholarships, nursing school literature, and preparation of press releases.

On a national basis, radio programs have been assured beginning March 10; newspaper advertisements have been prepared; a girls' magazine will conduct a national survey to determine interest in nursing, and another magazine will carry student nurse enrollment plans to women's clubs; 70,000 cards for use in street cars and buses are being made, and 45,000 window displays for use in stores, banks and post offices will be available.

A kit of publicity materials for individual hospital use, special letters and bulletins, and other recruitment aids will be prepared by the Association staff, Mr. Hayes said.

### Appoint Associate in Mathematics to Bureau of Medical Economics

Everett L. Welker, PH.D., has joined the staff of the Bureau of Medical Economic Research of the American Medical Association, Chicago.

Frank G. Dickinson, PH.D., director of the Bureau, in announcing the appointment, stated that Dr. Welker will assist him in all matters relating to statistics and statistical methods.

Dr. Welker received his PH.D. degree in 1938 in mathematical statistics from the University of Illinois, where he has been a member of the Mathematics Department since 1935. As associate professor he taught actuarial theory and courses in statistics at the graduate level. He will retain his association with the University of Illinois until June by conducting a Saturday seminar in mathematical statistics.



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## OBITUARIES

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### Louis M. Allyn, M.D. 1877 - 1946

Dr. Louis M. Allyn was born in Mystic, Connecticut, September 21, 1877, the son of Louis P. Allyn and Emily Fenner Maxson. During Dr. Allyn's early years he attended the local school in Mystic and followed it by attendance at the Westerly High School. He was graduated from there in 1896 and entered Lehigh University. After 2 years he transferred to the University of Pennsylvania in Philadelphia and received his M.D. degree in 1903. Following an internship at St. Joseph's Hospital in Reading, Pa., he opened an office for the practice of Medicine in Mystic in 1905 and maintained this office there until the time of his death.

In 1909 Dr. Allyn married Laura Greenman of Mystic. This marriage was blessed with two daughters. Mrs. Allyn died in 1922 and in 1926 Dr. Allyn married Rae Burnett of Mystic, who survives him together with the daughters.

Dr. Allyn had a very active career aside from that of a small town physician. He was very active in political circles, having served on the Republican Town Committee, Board of Selectmen, Town School Board and was chairman of the 5th district School Board for 24 years. He was greatly interested in the town's schools and was one of the prime movers in setting up Fitch High School and in establishing the original teaching staff. He was instrumental in starting the Mystic Oral School as a State institution and served as trustee for many years. He resigned that position to keep on as school physician when it became impossible for him to do both jobs.

Dr. Allyn was probably best known as health officer for the Town of Groton. He received this appointment in 1915 and continued in that capacity until his death. During his tenure of office the town had an enviable health record.

Dr. Allyn was a member of the Mystic Lodge of Masons and was a member of Sphinx Temple of the Shrine. He was a member of the Union Baptist Church of Mystic, serving as trustee for a number of years. He was a member of American Medical Association, New London County Medical Association,

Delta Upsilon Fraternity and John Guiteras Medical Society. His hobbies were hunting, fishing, boats, dogs, in fact anything to do with the outdoors. He established a bird sanctuary on the upper reaches of the Mystic River and prevailed on the State to take over the protection of birds in that area.

On May 31, 1946, Dr. Allyn died. He had been in somewhat precarious health for several years, in fact, since the hurricane of 1938. At this time he overtaxed his heart and never entirely recovered from the strain.

E. Roland Hill, M.D.

### Maurice J. Reidy, M.D. 1884 - 1947

Dr. Maurice J. Reidy, chief of the surgical staff of the Litchfield County Hospital, died at the St. Francis Hospital in Hartford on February 6, 1947, following a short illness. He was born in Winsted, August 19, 1884, the youngest son of Patrick and Ellen (Dillon) Reidy. After receiving his training he spent two years at Holy Cross, followed by four years at the College of Physicians and Surgeons of Columbia University in New York, graduating in 1910. After an internship of eighteen months at French Hospital, New York City, he returned to Winsted where he practiced with his brother, the late David D. Reidy, up to the time of his death.

Dr. Reidy was a member of the Litchfield County, State and American Medical societies. He was also a fellow of the American College of Surgeons. He was a member of the medical and surgical staff at the Litchfield County Hospital for more than thirty years. The greater part of these years he devoted to surgery, and later became chief of the surgical staff.

His two sons, Maurice J. Reidy, Jr., M.D., and Joseph C. Reidy, M.D., and numerous local residents will remember him for his sincerity and thoughtful understanding of those less fortunate individuals in need of medical or surgical attention. To those on the staff who knew him well he will be remembered for his congenial personality, diagnostic and surgical ability, kindly counsel and wisdom in time of need extended to his colleagues, young or old.

Roy V. Sanderson, M.D.

## SPECIAL NOTICES

### NATIONAL GASTROENTEROLOGICAL ASSOCIATION MEETING

The National Gastroenterological Association will hold its 12th Annual Convention and Scientific Session at the Hotel Chelsea in Atlantic City, N. J., on June 4, 5, 6, 1947, affording those interested in attending the centennial celebration of the American Medical Association and the meeting of the National Gastroenterological Association a chance to be present at both.

The program will consist of eighteen separate papers on various phases of gastroenterology and allied subjects.

There will be one Luncheon Round Table Conference on Thursday, June 5, 1947, at which time Dr. Hyman I. Goldstein of Camden, N. J., will speak on "The History of Gastroenterology and the Development of this Specialty in America."

At the Annual Banquet to be held on Thursday evening, June 5, 1947, the winner of the National Gastroenterological Association's 1947 Cash Prize Award Contest for the best unpublished contribution on Gastroenterological or an allied subject, will receive the prize of \$100 and a Certificate of Merit. The guest speaker of the evening will be Dr. Homer T. Smith of the New York University College of Medicine whose subject will be "Plato and Clementine."

Program and further details may be obtained from the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

### THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-fifth annual scientific and clinical session September 2, 3, 4, 5 and 6 inclusive, at the Hotel Radisson, Minneapolis. Scientific and clinical sessions will be given the days of September 3, 4, 5 and 6. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 2, 3, 4 and 5. These courses will be open to physicians and the therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

### SCHOLARSHIP FOR PHYSICIANS TUBERCULOSIS COURSE

Announcement is made by the Connecticut Tuberculosis Association, 43 Farmington Avenue, Hartford, of three scholarships for physicians to be offered by the National Tuberculosis Association for a four weeks' course at the Trudeau School of Tuberculosis, Saranac Lake, beginning September

8, and for which the tuition is \$100. Two additional weeks at Bellevue Hospital, New York City, tuition of \$50, is included in the scholarship, but is optional.

Because of the waiting list for the Trudeau School, the deadline for applications for the National Tuberculosis Association scholarships is May 15. Traveling and living expenses for the total of six weeks may be provided by the Connecticut Tuberculosis Association for the successful applicant.

Physicians interested in applying should write to Dr. Kendall Emerson, National Tuberculosis Association, 1790 Broadway, New York 19, N. Y.

### ATTENTION NAVAL RESERVE MEDICAL OFFICERS!

#### Opportunity for Active Duty

The attention of Reserve Medical Officers is invited to the opportunity to return to *active duty* at one of the major naval air stations of the Naval Air Reserve Training Command or at one of the Naval Air Reserve Training Units (NARTUs) listed below:

Atlanta, Ga.; Columbus, Ohio; Denver, Colo.; Dallas, Texas; Glenview, Ill.; Grosse Ile, Mich.; Los Alamitos, Calif.; Memphis, Tenn.; Miami, Fla.; Minneapolis, Minn.; New Orleans, La.; New York, N. Y.; Oakland, Calif.; Olathe, Kans.; Squantum, Mass.; St. Louis, Mo.; Willow Grove, Pa.; Anacostia, D. C.; Jacksonville, Fla.; Norfolk, Va.; Seattle, Wash.

Reserve Medical Officers who are interested in *active duty* at one of the stations or units listed above should initiate letters to the Bureau of Naval Personnel, via Chief of Naval Air Training, Naval Air Station, Glenview, Ill., and BuMed, listing three or four stations at which duty is desired in order of preference. Personnel are desired in rank of Commander and below in the Medical Corps. However, Captains may apply for duty in their rank, requesting waiver.

#### ADVANTAGES

Officers qualifying for the above billets will not be subject to transfer and may terminate the tour of duty at own request. Flight surgeons are assured of orders to duty involving flying. Government quarters are available at several of the major naval air stations. *Here is a chance for a reserve officer awaiting residency or fellowship in a civilian hospital to obtain a full time paying job in the meantime.*

#### ORGANIZED AND VOLUNTEER RESERVE AFFILIATION

Naval Reserve Flight Surgeons who desire to join one of the Navy or Marine combat air groups of the Organized Reserve training at one of the stations listed above should contact the local Commanding Officer for additional information. Two months pay per year is granted for attendance at all training periods.



## THE DOCTOR'S OFFICE

John Carangelo, M.D., announces the opening of his office for the practice of obstetrics and gynecology at 701 Asylum Avenue, Medical Arts Bldg., Hartford.

Stanley I. Czyz, M.D., former Captain, Medical Corps, U. S. Army, has begun the practice of medicine in Bristol at 257 Main Street.

Walter A. Dalmain, M.D., has announced the opening of an office at 72 North Main Street, Bristol, for the practice of orthopedic surgery, diseases and injuries of the bones and joints.

S. D. Firestone, M.D., has opened an office for general practice at 56 Park Street in Rockville.

Sam B. Kirby, M.D., of 461 Humphrey Street, New Haven, has resumed the general practice of medicine at that address after two years, eight months of service in the Army Medical Corps.

John J. McLean, M.D., announces the removal of his office to 64 Garden Street, Hartford. Practice limited to general and industrial surgery.

Andrew P. Owens, M.D., formerly resident physician of the Bridgeport City Dispensary, has announced the opening of an office at 385 Noble Avenue, Bridgeport.

John Purney, M.D., announces the opening of his office for the practice of gynecology and obstetrics, 797 Farmington Avenue, West Hartford.

Edmund C. Rup, M.D., son of Mrs. Caroline J. Rup and the late Anthony J. Rup of 1387 Boulevard, announces the opening of an office for the practice of general medicine at 951 Farmington Avenue, West Hartford.

Norman L. Schmidt, M.D., who served three years in the U. S. Navy Medical Corps as a Commander on convoy duty, has resumed the practice of urology at 60 Glenbrook Road, Stamford.

L. G. Simon, M.D., announces the removal of his office to 30 West Avenue, South Norwalk, for the practice of general surgery.

Mark Thumim, M.D., has become associated in the practice of eye, ear, nose and throat medicine with Dr. William M. Joyce and Dr. Carl C. Chase, who maintain a suite of offices at 121 Main Street, Middletown. Since May of 1946 he has been practicing the same specialty at 57 South Main Street. His own

office will be closed. Dr. Joyce and Dr. Chase have been associated since January 1, 1931.

R. Edward Vioni, M.D., has opened an office in the Medical Arts Building, 880 North Avenue, Bridgeport, and will specialize in allergy. Dr. Vioni has recently returned after a special year's study and research in allergy at the Research Institute of the University of Illinois which led to his being awarded the Master of Science in Medicine degree this year.

Fred Zaff, M.D., announces the opening of his office for the practice of radiology at 135 Whitney Avenue, New Haven.

## OUR NEIGHBORS

### Masachusetts

At a recent meeting of the Council of the Massachusetts Medical Society it was voted to appoint John F. Conlon, M.D., director of Medical Information and Education. A graduate of Boston College and Tufts College Medical School, Dr. Conlon is now attending courses at the Harvard School of Public Health and will assume his new duties on or about July 1.

The Council also approved that dues for regular members of the Society be raised to \$25, effective January 1, 1948; \$5 of this sum will be earmarked for the Boston Medical Library which is in need of financial assistance.

On March 26 the new Blood Processing Laboratory operated by the Massachusetts Department of Health was formally opened. This is the first state operated laboratory designed specifically for large scale blood processing and fractionation.

### New York

The Medical Society of the State of New York will honor its members who have practiced for fifty years or more by bestowing upon each a suitable certificate at the Society's annual meeting in Buffalo in May.

### Preliminary Report of Master Plan for Hospitals of New York City

An average of four general care hospital beds per 1,000 population are required for the care of New York City residents, according to a bulletin issued

in February by the Hospital Council of Greater New York in New York City.

In reporting some of the studies which have been made in the formulation of the Master Plan for the development of hospitals and related facilities in New York City, the Council suggests more efficient use of existing facilities rather than an increase in the number of general care hospital beds available.

Despite the general impression that hospitals recently have been overcrowded, studies made by the Hospital Council reveal that "less general hospital care has been provided during the past five years than during the previous five years." In 1945, 8,759,630 general care patient days were reported. The greatest amount of general care service was provided in 1939 when 9,104,519 patient days were recorded.

In making its studies of bed needs and other phases of the Master Plan which is to be presented this year, the Council divided the city into study areas, each with some of the features of a natural community. Although living conditions and other economic factors were found to influence the need for hospitalization, the Council reports that the death rate of a community reflects the other factors involved.

Studies show that approximately 120 patient days of general care have been provided in its hospitals for each death in New York City. The Council concludes that 0.41 bed per resident death should be available for the residents of the city.

Pointing out a variation in the general care bed needs of the residents of each borough, the Council stated that 4.7 beds per thousand population are required by Manhattan; 3.5 by the Bronx; 3.9 by Brooklyn; 3.6 by Queens, and 4.4 by Richmond. The Council states that "there is even more variation in the ratios for the study areas, which range from a low of 3.0 per 1,000 population to a high of 5.3." Provision for the care of non residents also is made in Council estimates.

Studies of the Council reveal that the proposed formula for calculating the number of general care beds needed does not require modification to include the birth rate of the community. "In analyzing this problem," the Council reports, "it appears that the age distribution of the population is an important factor, since the need for hospital beds is primarily for persons in the second half of life." The Council found that the areas with high birth rates had a greater proportion of their population in the young-

er age groups than did the city as a whole or the areas with low birth rates.

Other aspects of the Master Plan will be reviewed in future publications of the Hospital Council of Greater New York, a non profit organization, incorporated in 1938 to coordinate and improve the hospital and health services of New York City and to plan the development of these services in relation to community needs.

### Rhode Island

On February 5 the Woman's Auxiliary to the Rhode Island Medical Society was organized with Mrs. Herbert E. Harris as president, Mrs. Guy W. Wells, vice-president, Mrs. Charles L. Farrell, secretary, and Mrs. Jesse P. Eddy, 3rd, treasurer. Mrs. James R. Miller of Hartford was one of the speakers at the organization meeting, explaining the organization work and purposes of the Woman's Auxiliary.

The *Rhode Island Medical Journal* informs us that a recent press story in the *Providence Journal* reported that the Hospital Association of Rhode Island has urged upon the General Assembly the passage of a bill to increase from \$4.50 to \$8 the maximum daily rate allowed for hospitalization in workmen's compensation cases. Support for the measure was urged on the grounds that it is estimated that the voluntary hospitals of this State are spending on the average well in excess of \$12 a day in providing care to workmen's compensation cases. The question in the minds of some members of the Assembly is that if the private insurance carrier is to pay an increase for workmen's compensation policy holders then should the non profit Hospital Service Corporation not meet the same standard of payment to every hospital in the State.

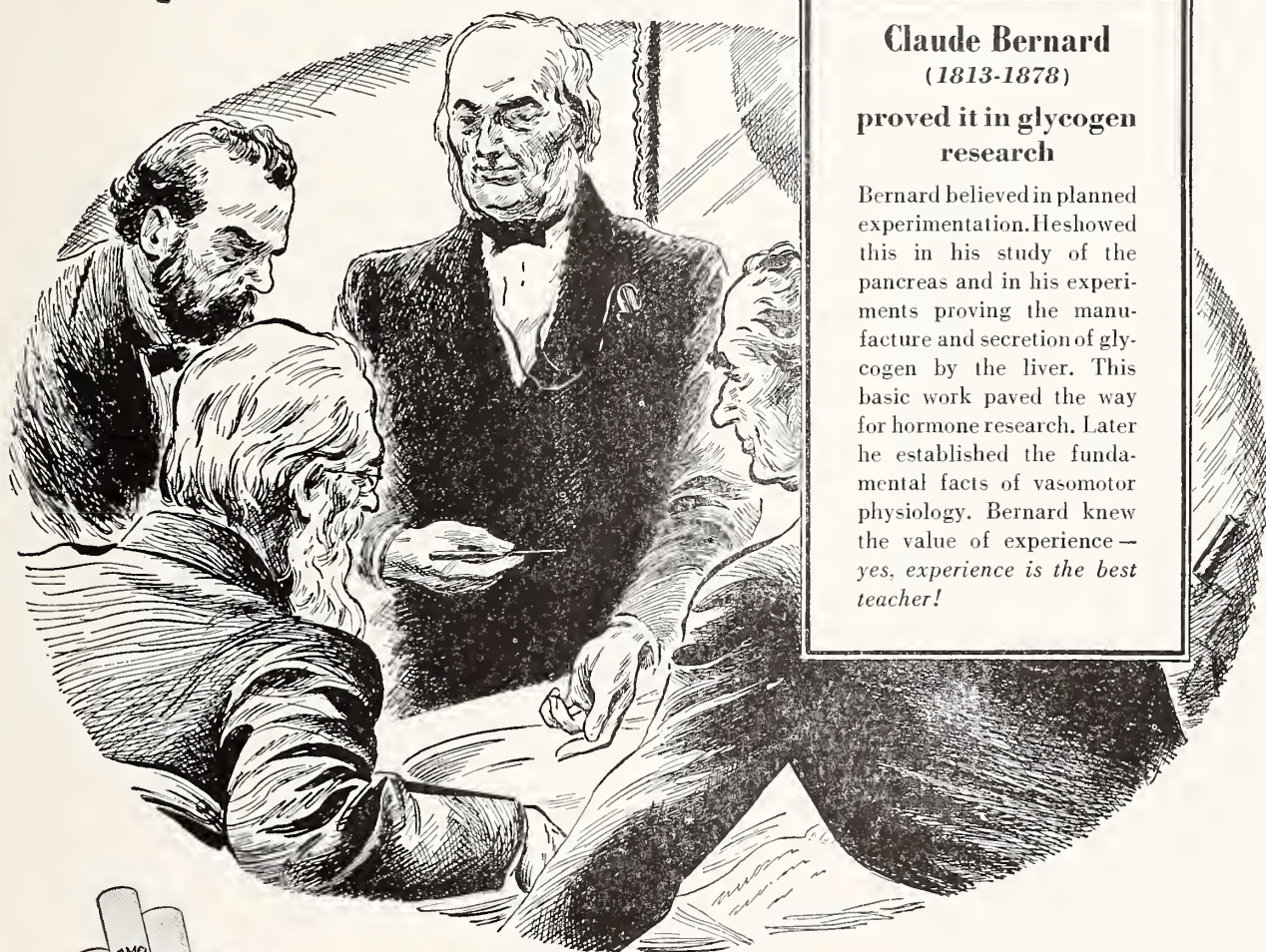
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### Wasted Talent

The Citizens Committee on Displaced Persons has issued a statement that 4,057 trained nurses and 1,135 experienced hospital attendants are languishing in UNRRA displaced camps in Germany, Austria and Italy. The Committee is backing legislation now before Congress as HR2910, as an emergency measure, which would permit 400,000 displaced persons to enter the United States at the rate of 100,000 a year. The bill is sponsored by Rep. William G. Stratton, Jr., Illinois Republican.



# Experience is the Best Teacher



## Claude Bernard

(1813-1878)

### proved it in glycogen research

Bernard believed in planned experimentation. He showed this in his study of the pancreas and in his experiments proving the manufacture and secretion of glycogen by the liver. This basic work paved the way for hormone research. Later he established the fundamental facts of vasomotor physiology. Bernard knew the value of experience — yes, *experience is the best teacher!*



*Yes, and experience is the best teacher in smoking too!*



THAT wartime cigarette shortage was a real experience to smokers. Millions of people smoked more different brands than they would normally try in a lifetime. And out of the comparisons of that experience so many more smokers came to prefer Camels that today more people are smoking Camels than ever before.

*We don't tamper with Camel quality. Only choice tobaccos, properly aged, and blended in the time-honored Camel way, are used in Camels.*

*According to a recent Nationwide survey:*

## MORE DOCTORS SMOKE CAMELS

*than any other cigarette*



## STATE OF CONNECTICUT

Open competitive examinations for Welfare Medical Director, \$6,300-\$7,500 and Senior Physician (Psychiatric) \$5,040-\$6,240 per annum. Candidates need not be residents of Connecticut. Last date for filing: April 24. Application forms at Personnel Department, State Capitol, Hartford, Connecticut.

Glendon A. Scoboria

Personnel Director

## NEWS

### *from County Associations*

#### Fairfield

The 155th annual meeting of the Fairfield County Medical Association was attended by nearly two hundred and fifty of its members. An unusually large number attended the business meeting which started at 4:30 P.M. in the sunroom of the Stratfield Hotel. After introducing and hearing from the guests from the state office and the other county organizations, the main business of the day was presented. The following officers were elected for the 1947-1948 year: President, J. Grady Booe, Bridgeport; Vice-president, Clifford Moore, Stamford; Secretary, George A. Buckhout, Bridgeport; Treasurer, Clifton C. Taylor, Bridgeport; Councilor, Berkley M. Parmelee, Bridgeport.

To the Board of Trustees for four years, Maxon Eddy, Bridgeport and Oliver L. Stringfield, Stamford; delegates to the House of Delegates for a period of two years, James D. Gold, Bridgeport (renominated) and Cornelius Conklin, Bridgeport (renominated) and for two years, John Frothingham, New Canaan, G. R. Eckert, Danbury; J. E. Starrett, Stamford; Kirby Howlett, Shelton; George Cody, South Norwalk; D. F. Keegan, Bridgeport; A. C. Smith, Danbury; Morris Pitock, Bridgeport.

Thirty-nine applicants were proposed for membership and favorably acted upon.

A very excellent paper on early ambulation following surgery was given as the president's address by our retiring president John D. Booth.

The following resolution was presented by James D. Gold:

Whereas it has come to the attention of this association that certain hospitals in this state have threatened to deny and otherwise have actually denied hospital privileges to duly qualified physicians merely because of their public expression and endorsement of a proposed bill relating to a medical subject now being considered by our state legislature;

Now therefore be it resolved that this Association go on record as being strongly opposed to and as deploring such action as undemocratic in that, in effect, it denies physicians the right to publicly express their convictions upon matters concerning the public health and welfare in violation of their right of freedom of speech guaranteed by the state and federal constitution.

Dated at Bridgeport this 8th day of April, 1947. (signed) The Fairfield County Medical Association

A motion was made and carried that this association endorse this resolution and send copies of it to every hospital in Fairfield County.

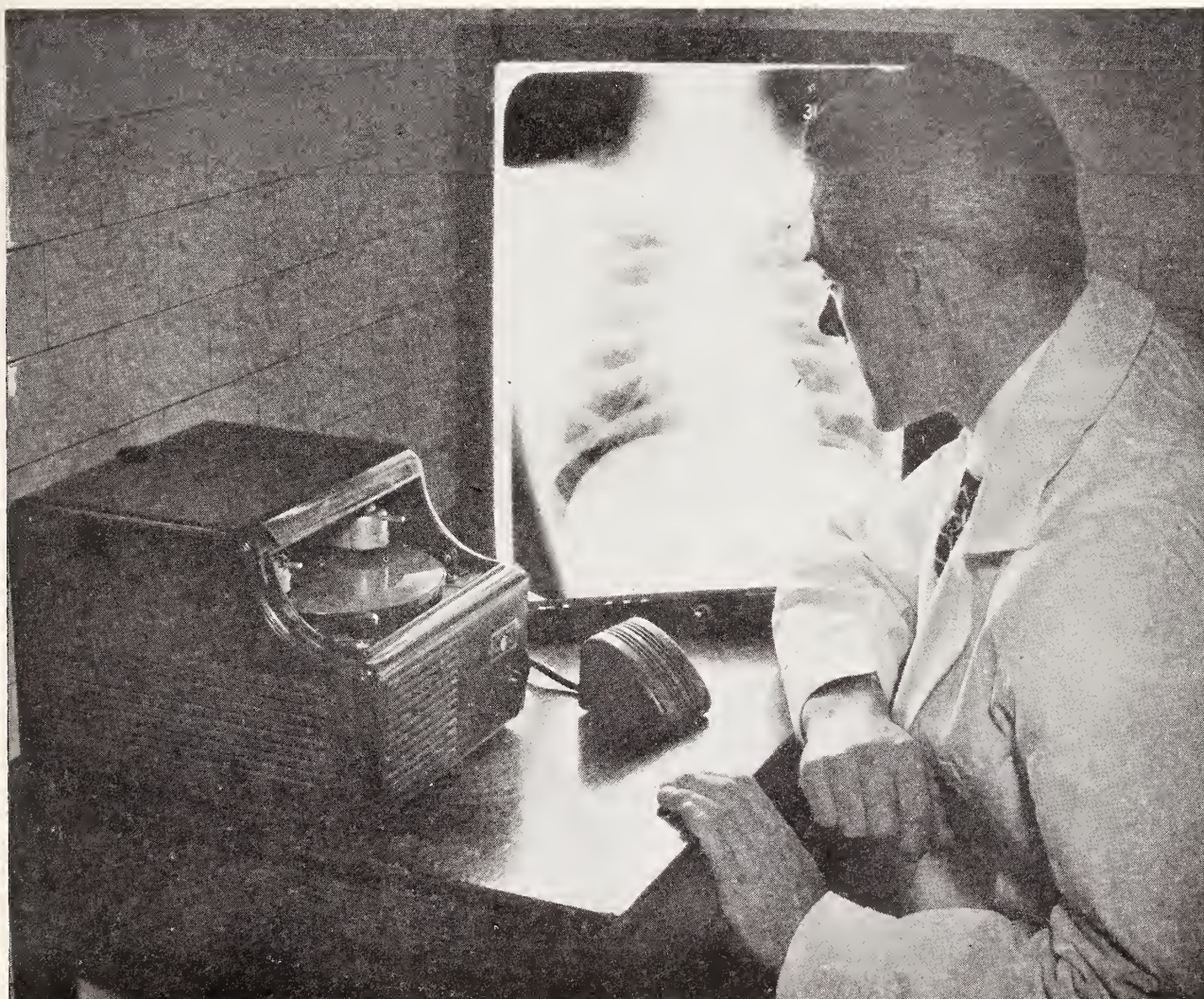
The business meeting over, the members, after a social hour, sat down to an excellent steak dinner in the ballroom of the Stratfield Hotel.

It would be impossible to properly describe the pleasure all had in listening to Morris Fishbein, editor of the *Journal of the American Medical Association*. He is indeed a spellbinder of the first water. His subject, Libel Suits Against the American Medical Association, was both interesting, humorous and remarkably informative.

The regular monthly meeting of the Bridgeport Medical Association was held at the University Club on the first of April at 8:30 P. M. After a short meeting all were entertained by a talk on The Recognition and Management of Cardiac Emergencies by Clarence E. de la Chapelle, professor of clinical medicine at New York University; associate dean and director of the new Postgraduate Division of the Medical College; visiting physician at Bellevue Hospital; attending physician in cardiovascular diseases at the Lenox Hill Hospital and chief of the Cardiovascular Clinic. Dr. de la Chapelle quietly and simply enlightened us on this subject and I am sure will be thanked many times over in the next year by men who now are better equipped to meet these emergencies. There was a lively question and discussion period joined by many members of the Association after the paper.



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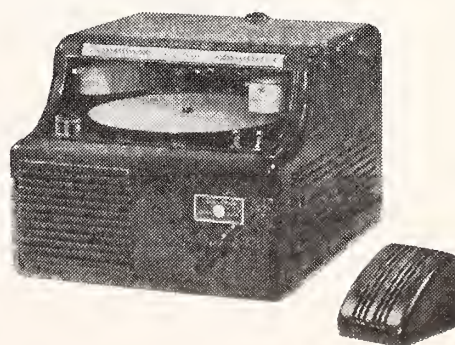
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Howard D. Moore, of Danbury, a practicing physician in that city for nearly 50 years, died at his home on March 28 in the 80th year of his life. He had been in failing health for several years and for the past five weeks was confined to his bed.

Three doctors have begun serving their internship in St. Vincent's Hospital. Cyril Chandler Blaney, M.D., a native of Westford, Mass., is a graduate of Boston University, and served in the Army Medical Corps five years. Robert H. Noonan, M.D., son of Mr. and Mrs. Robert E. Noonan, of 93 Mill Hill Avenue, is a graduate of Harding High School and Fordham University, and was a student in the Navy college training program. Lester G. Suzor, M.D., a native of Springfield, Mass., is a graduate of Laval University, Quebec, and served as chief medical officer in Fort Dix WAC Separation Center during the war.

### Hartford

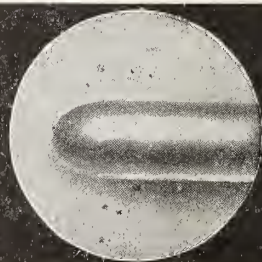
A medical office building to accommodate about 90 physicians will be constructed just north of the new Hartford Hospital wing by the Connecticut

Mutual Life Insurance Company, provided Civilian Production Administration permission is secured. The company has completed arrangements for purchase of the land from the hospital and will finance and own the building. Preliminary blueprints are being drawn by Moore and Salsbury, local architects, to conform with the construction of the new hospital, and actual construction will start as soon as approval is obtained and plans are completed. In addition to medical offices the building will contain druggist, floral, and other shops.

A new nursing service, known as the White Angel Nursing System, has been organized in Hartford to provide nursing care to home patients on an hourly basis. The service is available to the public and to physicians, and each visit has a maximum of four hours and a minimum of one hour. The organization includes only registered nurses, all part time workers, and is equipped to give emergency service to physicians from 11 A. M. to 8 P. M. daily. The system operates on a zone basis and each nurse is transported to her destination by car in order to give prompt response. A particular function of the

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service will be care of chronic invalids and new mothers.

H. Wilson Fancher, M.D., of Thompsonville, a practising physician in that town for more than twenty years, died suddenly in Springfield on March 19 at the age of forty-seven years.

At the annual meeting of the medical staff of the John B. McCook Memorial Hospital, Hartford, held on March 11 the following officers were re-elected for the ensuing year: Harry L. F. Locke, president; Claude C. Kelly, vice-president; Samuel A. Donner, secretary.

Henry R. O'Brien, M.D., senior surgeon (R) U. S. Public Health Service, formerly with the State Department of Health, is the author of "Health Conditions in Certain Large Cities of the Far East After Liberation," published in *Public Health Reports*, September 13, 1946.

The officers and committees of the New Britain Medical Society for 1948 have been announced as follows: President, Ladislaus B. Slys; Vice-President, George W. McMahon; Secretary-Treasurer, Raoul J. Benoit; Board of Censors, chairman, Vin-

cent J. Squillacote (3 years), Raoul J. Benoit (2 years), George W. Dunn (1 year); Executive Committee, chairman Ladislaus B. Slys, Raoul J. Benoit, Robert T. Scully (1 year), George W. McMahon, Robert S. Buol (3 years), Louis W. Daley (2 years); Medical Economics, John E. Darrow (1 year), Dwight E. Wilson (3 years), A. J. Wesoly (5 years), Carl J. Hart (2 years), Donald A. Bristoll (4 years); Program Committee chairman, Harold M. Clarke, Harry A. Parlato; Publicity Committee, Edward Resnik.

At the monthly meeting of the New Britain Medical Society held March 20 the speaker was Cushman D. Haagensen, associate professor of surgery at Columbia University College of Physicians and Surgeons, New York City. Dr. Haagensen outlined the large incidence of breast cancer and the essential need for early diagnosis and treatment. He stressed the fact that breast tumors may not necessarily cause pain or discomfort. Two out of every thousand women examined show this lesion. Thus if the problem is detected early the patient may expect a complete cure. Considerable research work is in progress at the present time in the use of hormones for the treatment of breast tumors. Encouraging results in selective cases have been reported. Dr. Haagensen also presented his own refinement in the technique of breast surgery and evaluated the position of x-ray and radium therapy.

The Manchester Medical Association had its annual bowling tournament on Wednesday, March 19. At that time the D. C. Y. Moore cup for the highest average score was won by Joseph Massaro. Howard Boyd, this year's president of the Association, placed in competition a President's cup to be awarded on a handicap basis. This was won by Robert Watson. The men are now husbanding their strength for the semi-annual meeting at the home of Douglas J. Roberts, which will be held about the middle of May.

Charles W. Goff of Hartford has been appointed to the New England States Regional Committee of the American Academy of Orthopedic Surgeons.

The annual meeting of the Hartford County Medical Association was held in Hartford on April 1. During the business meeting in the late afternoon the following officers were elected: Louis P. Hastings, Hartford, president; Charles T. Schechtman, New Britain, vice-president; W. Holbrook Lowell, Hartford, secretary-treasurer; C. Charles Burling-



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ame, Hartford, councilor; Harvey B. Goddard, East Hartford, censor. Lewis P. James of Hartford was elected to the committee on public policy and legislation and five delegates were elected to the State Medical Society: viz., S. Paul Coates of Suffield, James R. Cullen of Hartford, Maxwell O. Phelps of Hartford, William J. Watson of New Britain, and Benjamin B. Whitcomb of Hartford. Twenty new members were elected. Following dinner at the Hartford Club, retiring President Benjamin B. Robbins briefly summarized his formal address. The guest speaker of the evening was William W. Scott, professor of urology at Johns Hopkins University School of Medicine. His illustrated presentation of The Treatment of Cancer with Hormones was timely and interesting.

Peter Pizzi, M.D., of Rochelle Park, N. J., has been appointed to the staff of the Manchester Memorial Hospital as medical anesthesiologist as of April 15. Dr. Pizzi has had a long period of training in this specialized field and will come here highly recommended. He was endorsed for the local post by Dr. Ralph Tovell, chief medical anesthesiologist at the Hartford Hospital. He is married and has one child and will bring his family to Manchester to reside when he takes up his duties there.

### Litchfield

Gert M. Wallach, M.D., of Torrington has returned from Washington, D. C., where, for the last month, he has taken an extension course in obstetrics and gynecology at George Washington University.

### Middlesex

The County Medical Association met at the Griswold Inn, Essex, for its one hundred and fifty-fifth annual meeting. Inasmuch as this was a joint meeting to celebrate the centennial of the Central Medical Association, the only business transactions were the reports of the secretary and treasurer, the delegates and the councillor. The nominating committee brought in their slate the names of Frank Couch for president; Philip Schwartz for vice-president; Norman Gissler, clerk; F. Irwin Tracy for councillor and Thomas Horsefield and William Ames delegates to the State Society. The slate was elected unanimously.

Alfred Sweet, Mrs. Sweet and daughter Kitty are enjoying a sojourn in Florida. The Sweets are expected back around the first of May.

The Middletown Hospital tumor committee meet-



ings are becoming so largely attended that a new room has had to be found. They are now being held at the Auxiliary Cottage on the hospital grounds.

The weekly clinical conferences of the Middlesex Hospital staff have been organized so that a specific disease entity is being presented in a scientific discussion. Much credit is due to Christie McLeod for her arranging these very valuable conferences.

Mark Thumim has become associated with Carl Chase and William Joyce.

### New Haven

The Hospital of St. Raphael, New Haven, has announced the opening of a weekly tumor clinic each Tuesday from 9 to 11:30 A. M.

Several New Haven physicians recently attended the sectional meeting of the American College of Surgeons in Providence. Among them were Frederick Roberts, C. Seaver Smith, Samuel Rensch, John C. Mendillo, Nicholas Mastronard, Vernon Filley and Harris B. Schumacher, Jr.

The Intra-Urban Medical Society held its meetings in New Haven on April 4 and April 5. There were many out-of-town members including Dr. Longcope, Dr. Chester Keefer, Dr. J. C. Fox and others. The members of the Society were entertained by Dr. Francis Blake at the New Haven Lawn Club.

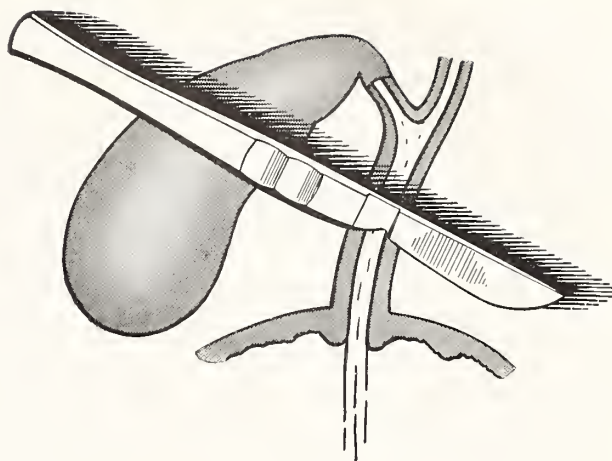
James L. Moriarty, M.D., of Waterbury died April 3, 1947. A long time member of the Waterbury Medical Society, Dr. Moriarty was active in orthopedics at both the Waterbury and St. Mary's Hospitals until his retirement a few months ago. Dr. Moriarty will long be remembered for his sense of humor and his witticisms.

### New London

James David Sawyer, M.D., has opened his office for the practice of medicine and surgery in Jewett City. Graduate of the University of Vermont School of Medicine in 1944, he served in the U. S. Army from July 1945 to August 1946. He recently served an internship at the W. W. Backus Hospital in Norwich. Our best wishes go to Dr. Sawyer for a successful career in medicine.

Drs. Henry Tulip, Thomas Holcomb and Robert Nolan will serve for a period of three months at the W. W. Backus Hospital in Norwich. Later they will enter upon their regularly assigned internships in other hospitals. They all recently graduated from the University of Vermont School of Medicine.

On Thursday, April 3, the annual meeting of the



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New London County Medical Association was held at the Seaside Sanatorium, Waterford. An unusually large gathering was present and they were amply rewarded with an interesting meeting and later a scientific program under the direction of Charles Stewart Welch, professor of surgery, Tufts Medical College, Boston. Dr. Welch spoke on The Controversial Aspects of Peptic Ulcer. A delicious dinner was served by the staff of the Seaside. Among our guests were James Raglan Miller and Stanley B. Weld, both of Hartford. It was by far the best and the largest gathering of the Association within the memory of the writer. Alfred Labensky of New London was elected president for the coming year. The other officers elected were Henry A. Archambault, Taftville, vice-president; Thomas Soltz, New London, secretary-treasurer; George H. Gildersleeve, Norwich, counselor.

### Tolland

At the annual banquet of the Rockville Fish and Game Club Dr. John Flaherty was presented with a

silver card denoting life membership in the club. Many testimonial talks were made, praising Dr. Flaherty as a sportsman and for his excellent work as chairman of the Board of Fish and Game Commissioners.

## News from Yale University School of Medicine

President Charles Seymour of Yale University has announced plans for the establishment next September of a graduate course in hospital administration, made possible by a grant from the W. K. Kellogg Foundation. The course will be an integral part of the teaching and research program in the Department of Public Health of the Yale School of Medicine. Clement C. Clay, M.D., newly appointed assistant professor of Hospital Administration, will act as director of the Hospital Administration Course.

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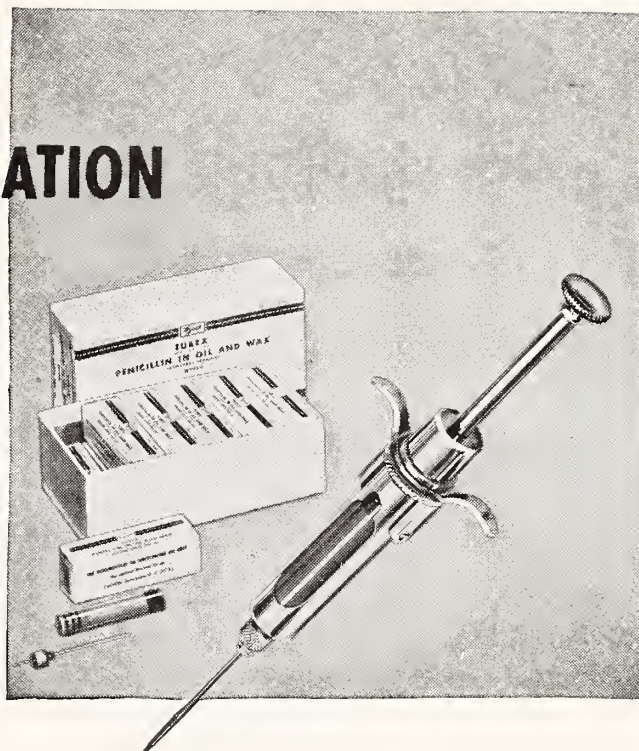


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Present plans for the course call for the utilization of facilities of the Grace-New Haven Community Hospital, appropriate University Departments and Schools, and hospitals and other agencies in the New England area.

The program of instruction will include basic background subjects as well as those related specifically to management of hospital. Through lectures, seminars, and actual practice work in hospitals, the students will be introduced to the function of each department of the hospital organization.

They will also acquire a knowledge of such subjects as admitting procedure, institutional house-keeping, laundry operation, plant maintenance, nursing service and education, medical staff relations, and the operation of the x-ray department, laboratories, pharmacy, and other facilities.

The total period of training will be at least 21 months, of which not less than nine months will be spent in residence at the University. Thereafter the student will become an administrative intern or resident in a hospital approved by the University for supervised practical training under an experienced administrator. Upon successful completion of the course, the student will be a candidate for a master's degree.

Three classes of students will be eligible for admission to the new course: Doctors of Medicine, graduate nurses who have a bachelor's degree, and individuals who have a bachelor's degree without special training in medicine or nursing. Some practical experience in hospitals or medical care agencies is a prerequisite.

Plans for the program of study were drawn up by Prof. Ira V. Hiscock, chairman of the Department of Public Health, and Dr. Albert W. Snoke, professor of Hospital Administration at Yale and director of the Grace-New Haven Community Hospital.

## NEW BOOKS IN REVIEW

*HARVEY CUSHING, A Biography* by John F. Fulton. Springfield, Illinois: Charles C. Thomas. 1946. 754 pp. \$5.00.

Reviewed by STANLEY B. WELD

Harvey Cushing, "scientist, pathfinder, artist, writer, and bibliophile"—that name has electrified American Medicine

and the effect of that dynamic life has been recorded across the continent of Europe. The biography of this foremost American surgeon of the last half a century, written by his talented pupil and friend of his later years, presents a panorama of a life full to overflowing. Harvey Cushing was a perfectionist. He was difficult to work with and under, and yet his friendship to many, rich and poor alike, brought boundless happiness and encouragement.

John Fulton has performed a remarkable task in combining data from a seemingly endless array of sources, not the least of which were the diaries and letters of the great neurosurgeon himself. His home life, his student days at Yale, his medical school experiences at Harvard, the resident years at Johns Hopkins Hospital, the fruitful years at the Peter Bent Brigham Hospital, service in World War I, and his closing years at his beloved Yale—all are presented to the reader with attention to detail which makes for a completeness and sustains the reader's interest to the end.

Certain phases of Harvey Cushing's life stand out in bold relief: his athletic prowess at Yale; his early surgical skill as a prosector at Harvard; his interest in the patient as a human being; his fearlessness in developing the art of brain surgery; his fondness for his fellow workers; his love of rare books; and his driving energy. Harvard Medical School may well point to him as its most distinguished graduate; New Haven, Boston, Baltimore, and his native Cleveland each share his fame. It was a dinner for this guest, a gift for that friend, a witty story at a gathering of medical friends, or an encouraging word to a patient which contributed to his greatness.

The biographer has wisely passed over many of the difficult moments in Harvey Cushing's life, realizing that these were far overshadowed by his successes. The record of degrees and honors deservedly bestowed upon Dr. Cushing cover four pages.

The publisher, Charles C. Thomas, was likewise a friend of Harvey Cushing. This product of Bannerstone House is a fitting testimony to that friendship. Illustrations, drawings, type and binding—all have been produced in a fashion to make this volume attractive. Medical students should find inspiration within its covers. Physicians will lay it down with a feeling of pride in this pioneer. Even the layman will discover it to be profitable reading, for few generations have produced his equal. To those of us who knew Harvey Cushing this volume has brought immeasurable pleasure.

*PRACTICAL PHYSIOLOGICAL CHEMISTRY.* (Twelfth Edition.) By Philip B. Hawk, PH.D., President, Food Research Laboratories, Inc., Long Island City, New York; Bernard L. Oser, PH.D., Director, Food Research Laboratories, Inc., Long Island City, New York; and William H. Summerson, PH.D., Associate Professor of Biochemistry, Cornell University Medical College, New York City. Philadelphia: The Blakiston Company. 1947. xiv + 1323 pp. 329 illustrations and 5 plates in color. \$10.

Reviewed by DAVID I. HITCHCOCK

The new edition of this book is more than 30 per cent longer and heavier than its immediate predecessor, the edition of 1937. Since the earlier editions have been widely used in medical schools since 1907, readers of this journal need no detailed description of the contents of the present volume.





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The revision seems to have been careful and thorough. New sections include those dealing with the polarograph; isotopes and their use in biological investigations; the determination of sulfonamides; metabolic antagonists and antibiotics; colorimetry and photometry, including the use of photoelectric instruments; and the use of the Warburg tissue-slice technique for the study of cell respiration. At the end of each chapter there is now a bibliography of review articles and books, and numerous references to journal articles appear as footnotes throughout the text.

The general plan of the book remains the same as that of previous editions; directions for experiments or analytical methods are interspersed between interpretive paragraphs or sections of textbook discussion. The reviewer does not like this plan, and he believes that other teachers share his preference for a textbook and a laboratory manual in separate volumes. However, the book is the most inclusive manual of biochemical methods now available in the English language, and it will undoubtedly be useful to many workers in all branches of medical science, as well as to students beginning the study of physiological chemistry.

**OPERATIVE GYNECOLOGY.** By Richard W. Te Linde, M.D., Professor of Gynecology, Johns Hopkins University and Chief Gynecologist, Johns Hopkins Hospital. Philadelphia: J. B. Lippincott Co. 1946. 751 pp. 309 illustrations and 9 color plates. \$18.

Reviewed by STANLEY B. WELD

The first innovation which strikes the reader's eye on opening Dr. Te Linde's *Operative Gynecology* is the format of the volume, arranged in two columns to the page with the latter slightly larger than the conventional book size. This together with a 12 point type makes the volume much easier to read. The actual number of words per page has been increased over the usual medical text book. The illustrations, both black and white and color plates, are excellent throughout.

No one should open this volume without first reading the preface. It presents one of the best summaries of the position of gynecology today in the practice of medicine, the proper approach of gynecologist to patient, and the need for adequate residency training in gynecology. In this era of specialization and subspecialization the importance of the thorough investigation of the patient as outlined by Dr. Te Linde cannot be overemphasized. In our haste to meet the demands of a large practice emphasis on the patient as a whole often suffers and needs to be repeatedly called to the attention of the gynecologist. The author is to be particularly commended for bringing to the attention of the reader the need for preparation in general abdominal surgery and the importance of a working knowledge of psychology and psychiatry.

There is much to be commended in this volume and very little to criticize. The use of first the avoirdupois system of dosage and then, a few pages farther on, the metric system is a little confusing. Perhaps it is a good example of the struggle still going on to convert all to the latter system. The author's conservative program of postoperative care is so conservative that it almost sounds reactionary. Diet, ambulation, hospital days—all reflect the program of a decade or two ago and are a little difficult to endorse with the improved well being so many patients now admit following major surgery. Perhaps

the Baltimorean female does require more of a rest as the author suggest than do our Northern patients.

The chapter on the anus and rectum deserves careful study, likewise the one on myomata uteri. One looks in vain in this latter chapter for the assignment of proper credit to the role of the uterosacral ligaments in hysterectomy. In the treatment of non malignant cervical lesions the high frequency coagulation electrode does not receive its proper share of consideration. The use of the vaginal smears stained by the Papanicolaou method is now being extended more widely than suggested by the author. A word of caution may well be raised relative to the discussion of estrogenic therapy of the menopause. This chapter is a bit misleading and does not emphasize the dangers from this therapy before uterus and ovaries have been removed. Estrogenic therapy in the so-called menopause has been responsible for many a curettage which might have been avoided. It is a relief to find the word x-ray decapitalized as it should be, rather than standing out all over the page with a large capital "X" for which there has never been any justification.

With so few modern texts on operative gynecology available, Dr. Te Linde's book will receive a hearty reception. The first edition has already passed through a second impression at the hands of the printer. The high price placed upon the volume seems to be no deterrent to its sale, good evidence of its inherent value.

**EYE HEALTH—A Teaching Handbook for Nurses.** Publication No. 447. New York: National Society for the Prevention of Blindness, Inc. 1946. 108 pp., illustrated. 60 cents.

Reviewed by MILTON F. LITTLE

This excellent handbook testifies to the painstaking care used by the Society for Prevention of Blindness in its preparation. It is divided into ten chapters and the entire book is only 100 pages in length, printed on non glossed paper and good ink, an excellent example for publishers to follow. This book should be required for both reading and study of all nurses, especially student nurses and graduate nurses associated with eye work in eye departments of hospitals, school nurses, industrial nurses and Public Health nurses.

The first two chapters are devoted to anatomy and neuro-anatomy of the organs of sight. Refractive errors, color vision, binocular vision make up the third chapter. The fourth chapter is an excellent one on home, school and office lighting. The next three chapters take up the diseases of eye of both adult and childhood. There is an excellent chapter on First Aid for Eye Injuries, and the final chapter is devoted to opportunities for the nurse to teach eye health, especially for Public Health and school nurses.

This very inexpensive handbook could very profitably be read by interns as well as general practitioners and pediatricians, and is so readable and understandable that it should be placed in every doctor's reception room.

The preparation and organization of the book have been enhanced by such international authorities as Dr. Arnold Gesell and Dr. Walter Lancaster.

The reviewer thinks that this handbook is by far the best that has come to his attention. It has fully served the purpose for which it was written.



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# *The* CONNECTICUT STATE MEDICAL JOURNAL

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## CONVOCATION OF THE SOCIETY, 155TH ANNUAL MEETING ADDRESS OF THE RETIRING PRESIDENT, COLE B. GIBSON, M.D.

THE 155th Annual Meeting of the Connecticut State Medical Society occurs at a time when it becomes increasingly evident that the conservation of health is more important than any other of our many domestic problems. The radio, newspapers, magazines, propagandists, columnists, civic clubs, and special interest groups have stimulated to a high degree the health consciousness of our people. Interest is not limited to the scientific prevention and treatment of disease. Attention is being directed toward other factors that play important parts in the maintenance of health, such as housing, nutrition, clothing, recreation, conditions of employment, and more notably, the availability of health facilities such as hospitals, clinics, and adequate medical care for all of the people.

This active interest in matters of health, we are told, is but another evidence that we are in a vast process of change. More and more, we become conditioned to the theory that future life will exist in a world of vastly different social, economic, and health surroundings.

As physicians we must appreciate that it is our responsibility continuously to alter, reconstruct, and broaden our concepts of medical care to meet changing requirements. Too, we need constantly to improve the machinery and tools of medicine that they will not only meet our current needs but that they may also be adaptable to conditions of the future.

One of the most complex machines of medicine with which the physician has to deal is the hospital. The many phased procedures and services performed in the hospital by people for people constitute as a whole the most important function in any community. Dr. J. J. Golub, director, Hospital for Joint Diseases, New York City, has said: "The effects of

the changing world on medical care and on hospitals in particular are so marked that a critical examination of its aims, functions and operations seems called for in every hospital today."

There are many who will agree with Dr. Roger W. De Busk when he says that "American hospitals have grown without the slightest evidence of plan or pattern. . . . The agencies which established our hospitals did so independently with resultant overlapping and broad waste of time, money, and material."

That this opinion was widely held was indicated by the passage of the Hospital Survey and Construction Act by the last Congress. The proponents of government control of medical care did not fail to emphasize the unbalanced distribution of hospital beds in the nation as evidence of need for central authority. Scarcity of small community hospitals in sparsely populated districts was held to indicate improvident planning on the part of the medical profession.

These and other happenings denote that the question of hospital distribution is receiving searching examination. Results of these studies portend numerous changes, and some are vital to the progress of medicine. Currently, the trend happily is toward a combination of guided, cooperative planning with local control of function. Whatever changes may come it is important that a locality, community, or state should be free to determine its own needs, and morally it should meet these as far as possible. If grants-in-aid are necessary, the community should be responsible for the manner of their distribution.

The increased use of hospital beds by the people constitutes a remarkable and continuing change. The steady year-to-year build-up of hospital patient days in the United States is of tremendous significance to

any hospital planning of the future. Ward bed facilities, and out patient machinery to a lesser degree, are no longer in such great demand; whereas more private and semi-private accommodations are required. This has come about because of improvement in the economic level; the public's fear of the hospital has been lulled by gradually learning that care of the sick is more convenient and more efficient in the hospital than it is in the home; increased numbers of people are covered by hospital insurance; physicians hospitalize more patients for study and treatment, for their own convenience and because of the specialized personnel and equipment for diagnosis and treatment that are readily available.

Increasing familiarity with the hospital is bringing people to realize what the hospital really is; what its functions are; what it means to the life of the community. They are coming to understand what the hospital is not; that it is not a necessary evil, not the end of hope, not a laboratory and workshop provided for the doctors at public expense. The thought is fast emerging that an adequate hospital is an essential community need; that it is the keystone of the arch of health, and that it is the duty of the community, morally and materially, to give full support to this vital structure. Thinking of this character will undoubtedly condition the plans for the physical plants of our hospitals of tomorrow. Moreover, it may be expected that boards of directors, the administration and the professional staff jointly interested in furnishing comprehensive medical care to a community, will progressively initiate and expand the services of the hospital to meet the changing order.

Implicit in such planning will be the educational aims and facilities of the hospital—both for the public and for the staff. For instance, certain hospitals formerly have culled their clinical teaching material from ward beds and outpatient clinics. With the large increase in admissions to private and semi-private accommodations, the occupants of these must be brought to a willingness to participate in the education and training of the staff.

Similarly, the education of interns and residents will receive even more careful thought and planning in the future, particularly in the local community hospitals. Vision and industry on the part of the senior staff can provide rich experience and training for young physicians. Along with this it may be expected that increased attention will be given to the matter of certification. Increasing numbers of hos-

pitals require or are planning for certification as prerequisite to appointment to senior staff positions. This phase of hospital practice continues to broaden, and future developments may have significant effects upon medical education and hospitals.

At the present, considerable thought is being given to the relationship of the general hospital to tuberculosis, neuropsychiatry, the patient with communicable disease, and the long term patient. The responsibility for providing hospital facilities for mental disease, tuberculosis and other communicable diseases has usually fallen upon central government and taxation, most often at city, county, or state level. It was apparently concluded that the people were entitled to public control of such patients and protection from them on the same basis that they are entitled to control and protection by police and fire departments. In the main, facilities provided were remote from the atmosphere of the general hospital. Similarly, the long term patient with chronic disease or the aged infirm patient was relegated to custodial institutions.

It is obvious that these methods have resulted in a state of clinical separatism, which according to many who are interested in extension of more adequate care, indicates need for examination and some definite changes. In modern hospital planning there is a trend toward setting aside a section for communicable diseases, so that these patients are dealt with not as a pariah group; and nurses and young physicians can develop experience and facility in the control of diseases which can become epidemic.

More hospitals are giving thought to the establishment of neuropsychiatric units. The advantages of such a system are: It meets the need for incorporating psychogenic and personality factors in diagnosing and treating individual patients; it offers a plan to meet the problem of the tremendous army of emotionally ill patients which gravitates between regular medicine and mercenary quackery; the transiently ill can receive care without the stigma of institutionalization; delirium complicating medical or surgical cases is less disturbing to the hospital and is more efficiently treated without restraint in a psychiatric department; the psychiatrist gains additional insight into the problems of his patients in consultation with physicians skilled in other fields; the educational possibilities for nurses, young physicians, and other staff members are enormous, and this could do much toward bringing psychiatry into the fold of general medicine where it belongs.



Connecticut has a good tuberculosis control program including sanatoria and case finding services. It enjoys a low death rate from the disease. The majority of Connecticut hospitals, however, manifest a striking need for change in their attitude toward tuberculosis. There are but few hospitals in the state that will admit a known tuberculous patient for treatment of a non-tuberculous condition, even in an emergency. Certain hospitals insist that a patient admitted for treatment for a non-tuberculous condition and found to have tuberculosis, must be discharged immediately, regardless of his condition.

Besides the direful results that may come from such policy, young physicians miss the opportunity which they should have for observing tuberculosis. Few nurses' training schools include instruction on tuberculosis in their curricula. Affiliation of these schools with sanatoria for training in tuberculosis nursing is negligible. To some extent, this attitude may have developed because of the well known relatively high incidence of tuberculosis in interns and nurses.

In this connection, too much stress cannot be laid on the importance of tuberculosis case finding in the general hospital. Chest plates on all patients at the time of admission provide good investment for the hospital, its personnel, and for the community. It must be clear that through some mechanism the phthysiophobia of many of our hospitals must be eliminated.

A variety of factors, but particularly chemotherapy and the antibiotics, have lengthened the span of life. This has brought many new problems, and medicine has a new specialty, geriatrics. Hospital facilities for the aged infirm, the chronically ill, or for long term patients, have long been inadequate in quantity and quality. Many inmates of custodial institutions need hospitalization as long term patients. They present a sharp challenge to the physician and the hospital hitherto absorbed in the dramatic interest supplied by short term patients. Many would improve under the regimen of a general hospital and, indeed, some might conceivably get well. The medical profession realizes that the aged sick must be considered as individual patient problems, and that hospital facilities should be more readily available to the increasing numbers of these in our population. Here again is a field in which we may expect change.

High cost of medical care, particularly hospital care, is a topic that for long, interested people only

when they had to pay for it. It has now become a matter of national importance, and if we are to believe some exhorters, it is also a national disgrace.

The simple fact is, good hospital care that brings comfort and hope to the sick is cheap at any price. The provision of good hospital care requires proper physical facilities, modern precision equipment, and skilled personnel which must be bought at the prevailing market. Modern miracle drugs are expensive to produce and expensive to administer.

In eras of high prices or low prices, the cost of food and household supplies is at the same relative level for hospital and homemaker alike. What focuses attention upon the alleged high cost of hospital care is that for so long people did not budget or plan for sickness; and many found themselves in dire financial straits when faced with catastrophic illness.

It appears that changes are coming, designed to make less painful the costs of more extensive medical and hospital care. Plans for this are numerous; many are already in operation. Clamor for comprehensive systems, including federal control, comes loudly from certain sources. It is doubtful if any single, simple program can be devised to meet a problem which affects so many people, living under widely diverse conditions in all the varied communities of our nation.

Before consideration of any plan it must be made unmistakably clear that man's health, along with shelter and food, are moral responsibilities of man, himself. These he must maintain and provide to the limit of his ability. Only when he has done his utmost does it become the duty of the community, for the preservation of the community, to come to his aid.

It follows then that to develop machinery to provide adequate medical care for all of the people, a complex, yet all covering plan must be devised. This must be free from paternalistic or dictatorial government control, lest man lose confidence in himself and come to lose his self reliance. Voluntary health and hospital insurance, widely spread, is a large part of the answer for our people who live and work under a system of free enterprise. For those unable to purchase such protection, means must be found to supply it. Greater availability of tax funds, with less politics and more brotherly love exercised in their distribution, could furnish the remainder of the answer, and this would be a change ardently to be hoped for.

It does not appear to be generally understood that

a hospital, in order to provide adequate service to its sick patients, must be staffed with trained, skillful, conscientious employees. Certainly, if one gives thought to the matter, particularly at a time when a loved one is in the hospital, he will readily agree that such personnel is far more important for the institutional care of the sick, his sick, than it is for the factory, farm, or store. Under the emotional stress of illness, patients and relatives may demand a quality of care which they cannot conceive may require years of training even in adaptable people. Having received such care and made recovery, interest often fades, and there is little concern for the quality of care that will be provided for the next occupant of the bed that has been vacated—or for the individuals who will supply that care.

Without bitterness, it can be said that the constantly improving quality of care and attention in our hospitals has not been due to the high wage level of hospital employees. Considering the character of their duties, the functions they perform, and their contribution to mankind, it is undeniable that in good times or bad, hospital personnel is woefully underpaid.

Employee shortages in many hospitals today have resulted in thousands of closed beds—beds that should be available for the comfort of the sick. To induce people to work in hospitals so that these beds may be opened there must be a fundamental change in the evaluation of the services that hospital employees perform. It must be realized that it is at least as important to preserve life in a hospital as it is to make machines to destroy it.

The shortage of nursing personnel in the United States today is so severe as not only to obstruct the proper distribution of medical care, but it also imperils the lives of thousands of puzzled people. There is little hope that this situation will be alleviated in the near future if some drastic changes are not forthcoming.

It has been pointed out that the aims, aspirations, and professional ideals of the nursing profession have undergone revolutionary changes in recent years. It should be pointed out also that some of these changes were evolutionary and entirely laudable. Some were due to unfortunately misplaced emphasis by leaders in the nursing profession.

For years the rigors incident to the schedule of training for nurses have been common knowledge. The registered nurse has been the competent right hand of the able physician, and dependable in her

own right, for the further extension of medical care. She has been held in almost reverent regard by her grateful patients. She has been the envy of her less consecrated sisters in the business world. Her economic status, however, was never commensurate with the training and application necessary to meet the demands made upon her profession. In short, she was underpaid for the quantity and quality of the work which she performed.

In an attempt to remedy this situation, nurses' associations developed programs to focus attention upon the importance of thorough training for the nursing profession. They insisted that nursing, particularly in hospitals, should be practiced only by graduate registered nurses. In many states they were successful in establishing legal statutes to effect this. Theoretically, this process should have improved the quality of nursing care in hospitals; it should have elevated the standing of the nursing profession, and it should have brought the nurses remuneration compatible with their professional calling.

Unfortunately, however, the shortage of nurses continued to increase. In civilian hospitals it was emphasized when thousands of their nurses entered the Army and Navy. Since the war, conditions have grown steadily worse. One cause of this is alleged to be that higher scholastic requirements are preventing many girls with aptitude for training in nursing from entering training schools. This innovation was integral to a plan for broadening hitherto auxiliary academic training in order to lead to degrees. Incidentally, this involved the elimination from the duties of graduate nurses those tasks considered to be menial rather than professional. The result is that up to now, registrations throughout the country have fallen to an appalling low level. The nurses who entered the Army and Navy were commissioned as officers, and in large measure they were able to direct enlisted personnel in the menial tasks of caring for the sick and wounded while the officer-nurses devoted themselves to professional duties. Nurses returned from the services with this background of experience have in large numbers declined to return to the homely tasks of civilian hospital nursing.

Also contributory is the fact that nursing hours are more demanding and less remunerative than are the hours in other fields of endeavor.

From all of this, certain facts stand out, and from these we should be able to initiate changes that might lighten our present difficulties, and make way for a future unburdened with such a trying problem.



The most important duty a nurse can perform is to render adequate care to a sick patient. Bedside nursing is the foundation of the nursing profession. The performance of distasteful procedures in the process of caring for the sick lowers the dignity of no one. The practice of the healing arts is based upon such traditional philosophy. Calling everything menial and non professional that is unpleasant, and classifying as professional only those duties that border on medical care, could lead far afield were the other professions engaged in healing to follow the same principle. There is no more reason for an inadequately trained nurse to delegate the making of a sick bed, the giving of a bed bath, and above all, the handling of a bed pan, than there is for a highly skilled physician to require an orderly to open a foul abscess, or treat a rectal disease or gonorrhea.

There is no quarrel with the desire for academic training or academic degrees. But academic degrees in nursing should follow in those nurses with superior scholastic attainments only after they have developed efficiency in bedside nursing and have proved their ability in their profession. Primarily, scholastic requirements should be made to fit the needs of general bedside care so that a greater number of girls who have general aptitude for nursing will be attracted to the profession. Postgraduate study for those nurses with higher educational levels should be planned to meet the ambitions of those desirous of academic training and degrees.

Leaders in the nursing profession seem to have forgotten that important as their profession admittedly is, it is still only an auxiliary to the medical profession and the hospital. Hospitals and medical societies are not without blame in permitting a slackening of the ties between the physician, the nurse, and the hospital. The time for change in all of this is now.

Some hospitals already are conducting on-the-job training courses for attendants, hoping thereby to meet the present desperate situation. This is not, must not be the final answer. The honorable nursing profession holds the grateful respect of all. Adequate care of the sick depends upon the professional ability of the solicitous nurse in cooperation with the skilled physician and the efficient hospital.

The time has come when this triad should reunite in an understanding, mutual bond to provide the best possible medical care to the greatest possible number of people.

If we are reluctant to admit that change is inevitable and desirable in the field of medicine, we must concede that in our professional lifetime we have seen enormous improvements in the conservation of health in many directions. Better economic conditions and elevation of the general educational level have, of course, contributed greatly to this progress.

At the same time, medical science has developed new technics and new materials that have altered completely our outlook on certain diseases and conditions. We have seen steady expansion of facilities for extending adequate medical care to more and more people. Evolution in the field of preventive medicine, and discovery of specific methods for limiting the course of disease have had astonishing effects upon life expectancy.

Some of these developments have come with incredible speed in the past few years, and some of us may feel a complacent pride in the present position of medicine. Surely, however, in light of what we, ourselves, have seen, none can feel that the acme has been reached. We must recognize all of this as progress, and we must accept as fact that "change is a law of life, and to cope with change adequately is a challenge to the living."

## NEWER THERAPY FOR EPILEPSY

MARGARET LENNOX, M.D., *New Haven*

IT IS ESPECIALLY fitting that you have selected epilepsy as one of the subjects for discussion on your program, and that you have chosen the particular subject of newer therapy in epilepsy. In recent years, advances in drug therapy have brought about a tremendous change in the outlook for patients with epilepsy, but further improvement in the outlook for these patients can be achieved with the help of the social worker or social therapist.

Epilepsy is an ancient disease; in fact it antedates man himself. It is also a chronic disease. Epilepsy, by definition, means a disease characterized by recurrent seizures. If untreated, it may be a severe handicap for years or for life. And finally, it is an important disease, since an estimated one out of every two hundred individuals is affected. In spite of the importance of this disease from many aspects, it has been one of the neglected fields of medicine until the fairly recent past. Phenobarbital, one of the most useful drugs in the treatment of epilepsy, was not introduced until 1912 by Hauptmann. Interest in the field was stimulated in the 1930's by several developments. Dr. William Lennox described the blood chemical changes in patients with epilepsy—changes which reflect metabolic and circulatory changes in the brain. Dr. Hans Berger described the technique of recording the electrical activity of the brain by means of the electroencephalograph. In this country, Lennox, Gibbs and Gibbs were among the first to apply this technique to the study of epilepsy. In 1937 Putnam and Merritt published the first report on the use of dilantin in epilepsy. The surgical treatment of epilepsy has been carefully investigated by Penfield and has received recent impetus from experience with the war wounded. Finally, there has been an increase in lay interest in epilepsy. Improved medical treatment of the disease is beginning to result in more favorable public attitudes. More people are beginning to realize that the "epileptic" is not a retarded individual with a peculiar personality who should be segregated from other individuals, who is

unfit for school and work, and who should not marry and have children. On the contrary, people are beginning to realize the truth—that the "epileptic" is like anyone else except that he has a medical illness, which can be investigated and treated like any other illness—like diabetes or tuberculosis, for instance. This improved public attitude is a tremendous asset in the treatment of epilepsy.

The drug treatment of epilepsy is being improved rapidly. The type of drug which can be used depends on the type of seizure the patient has. Grand mal and psychomotor seizures respond most readily to dilantin and phenobarbital, alone or in combination. It is important that the drugs be given in adequate dosage. The addition of one or two capsules a day of dilantin may change an individual who is incapacitated by seizures into one who is seizure free. Mesantoin is a new drug which may produce better results than dilantin in some individuals.

Within the last year a drug has been made available which is effective in the treatment of petit mal seizures. This type of seizure almost always occurs in children. The spells themselves are brief and mild and produce no harmful sequelae but they may occur so frequently as to be incapacitating, and they are often made worse by the usual anticonvulsant medication. Tridione, however, may eliminate petit mal seizures completely in a third of the cases. The drug has to be taken under close medical supervision because of serious and occasionally fatal toxic effects.

At present the results of drug therapy in epilepsy are distinctly encouraging. Many patients—probably more than half of non institutionalized patients—have no or rare seizures as long as they take their medicine regularly and in adequate dosage. Many other patients are greatly improved. More encouraging is the fact that new drugs are being developed and tried out all the time. There remain a few patients, probably less than 5 per cent of patients in



clinic practice, who have what can only be described as malignant epilepsy. In spite of adequate treatment, seizures continue or increase and, in the course of time, mental functioning may be impaired. Unfortunately, there are no adequate facilities for the treatment and study of these patients. If the spells are severe and incapacitating, it may be difficult or impossible to care for these patients at home. For a number of reasons it seems inadvisable to institutionalize mentally and emotionally normal epileptic patients with mentally defective and psychotic patients. The ideal arrangement would be to establish hospitals where the patients could be under close medical supervision, where facilities could be made available for teaching both children and adults, and where research by and training of doctors, nurses and social workers could be carried out. Such a hospital has been provided for by the veteran's administration at Framingham, Massachusetts. It may serve as a model for other institutions throughout the country.

In the majority of ambulatory patients with epilepsy, no organic brain pathology can be demonstrated. In a few, however, the seizures are due to localized brain abnormality, such as a tumor or a scar. In many of these cases, surgery effects a cure, although the great majority must continue to take medicine.

The third form of therapy, which, like drug and surgical therapy, is undergoing rapid refinement and development, is social therapy. Like drug and surgical therapy, social therapy must be adapted in every case to the individual. There are no rules that hold for all patients with epilepsy.

Patients with epilepsy have a number of social problems which they can be helped to solve. It is my impression that to the great majority of patients the seizures themselves present no problem. Unless there is a terrifying aura, or severe post-convulsive symptoms, the patient himself only knows that he has fainted or passed out. He does, however, live in constant dread of the opinion of other people. He dreads the seizures because they frequently cause excitement and anxiety in his family, derision and dread in friends, exclusion from school or work. This problem can be tackled from several angles. First, the patient himself must come to the realization that his illness is not shameful or disgraceful. It is no more shameful to have brain cells that sometimes beat unusually fast than to have a rapid heart rate. This realization cannot be accomplished quick-

ly or after one reassuring sentence, but after it is once accomplished the patient frequently has a whole new outlook on life. Secondly, the patient must learn to recognize and face the social stigma attached to his illness. The stigma is irrational and unwarranted. It is based on the superstitious notion that any phenomenon which is not readily understood is to be dreaded. But it exists. By the joint efforts of patients and interested laymen and physicians, the stigma has been greatly lessened in the past few years, and will be eliminated in time. Meantime this problem, which is essentially an educational one, deserves the attention of all interested individuals. The American Epilepsy League has been a pioneer in this field, and has accomplished a great deal by distribution of information to doctors, patients, employers, teachers and so forth. Finally, the patient's adjustment to his illness can be made much easier if his seizures can be controlled. As I have said, it is the rare patient who cannot be greatly helped.

In some instances, patients with seizures may also have mental deficiency. The reason for this association is clear. Brain injury, occurring at birth or later, or congenital anomalies of the brain, may give rise to mental deficiency as well as to epilepsy. In the majority of institutionalized epileptics, who constitute about 10 per cent of all epileptics, mental deficiency is the more important symptom and is the chief reason for institutionalizing the patient in the first place. The majority of ambulatory patients have seizures which are not due to brain injury and the average intelligence of ambulatory patients with epilepsy is that of the total population.

Social counselling includes helping the patient to obtain schooling and employment. Many schools exclude children who have seizures. This is, of course, undesirable for the child. The other children take their cue from the adults. If the adults become panicky at the sight of a seizure, the children will too. If the child with seizures is dealt with as matter of factly as the child with measles, the other children suffer no psychic trauma from having the child with seizures in their midst.

The question of employment must always be dealt with individually. If the patient is seizure free on medicine, or if seizures occur only at night, his illness need not bar him from any job or profession. If on the other hand, he has frequent seizures in the daytime, both the employer and the patient must be protected from undue risk.

Finally, social counselling includes advice as to marriage. First as to the facts. Hereditary factors are important in the causation of epilepsy—more important in some cases than in others. Just how a predisposition to seizures may be transmitted is not clear, but it is known that epilepsy is four times as frequent among relatives of patients than among the control population. Even so, the chances are slight that the child of an epileptic will have epilepsy. The chances are increased if there is a history of epilepsy in both the maternal and paternal lines, and are decreased if the parent's epilepsy is due to some organic cause.

Those are the facts. Do they justify the blanket advice that epileptic patients should not marry or have children? I think not. If, in some future time,

all marriages are arranged for purely eugenic reasons and if it is then possible to eliminate all hereditary diseases such as diabetes, cancer, hypertension and so forth, then it would certainly be wise to advise patients with epilepsy and their relatives not to marry. In certain instances, of course, other symptoms such as mental deficiency, psychosis or alcoholism may make a marriage unwise, but it is then these symptoms which determine the decision and not the epilepsy per se.

The treatment of epilepsy, as I have tried to show, consists primarily of the administration of drugs, but surgical and social therapy are important adjuncts and in many cases may be decisive.

## THE PHYSIOLOGIC REACTION TO RADIOACTIVE ISOTOPES

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THE radioactive isotopes are at present the most useful tool for medical and biologic research available to us. In addition, they hold some promise as a means of specific radiation therapy of certain disorders. I shall review briefly what is meant by radioactive isotopes. These are elements having the same chemical properties as the normal element but differing from it in physical composition. The radioactive isotopes are unstable, and as a result of that instability give off radiations of alpha, beta or gamma type neutrons. The bulk of radioactive isotopes which have been found useful up to the present time give off either beta or gamma radiations.

These radiations are not given off all at once but are liberated in orderly fashion, each isotope having a characteristic and unchanging rate of emission. It is convenient to consider them from the standpoint of the half-life, or point at which 50 per cent of the material has delivered its radioactivity and become inert. In weighing the isotopes as either research or

therapeutic tools, it is important to consider the range and type of radiation given off, the length of the half-life, and the chemical properties of the material. A substance that has too short a half-life cannot be worked with effectively. One that has too long a half-life will either not deliver its radiation at a rate sufficiently high to be significant from the therapeutic standpoint, or it will not be safe to use because of the prolonged character of the radiation.

Selective absorption of a given element is also an important aspect from the therapeutic standpoint. Thus, a radioactive material introduced into the body has no advantage over external total body radiation unless there is selective deposition of it in certain regions in which it is desirable to concentrate the radiation. Other aspects to be considered, of course, are the possible toxic effects of the material; thus, radium or radon, long available, have not been feasible to use either as tracer substances or for internal therapy because of their high toxicity, their slow excretion, and the prolonged radioactivity associated with them and their breakdown products.

Let us take radioactive phosphorus as an example and see how it has come to be perhaps the most widely utilized for therapy of the various radioactive

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isotopes. First, phosphorus is a normal constituent of the body. Second, the half-life of the radioactive phosphorus is 14.3 days, a long enough time to permit the necessary technical manipulations to be carried out prior to its administration and short enough to avoid any long range toxic effects. The material is absorbed approximately ten times as much by certain rapidly growing types of cells, as for example, the white blood cells in leukemia, as by cells growing at a normal rate. Finally, the end-product of the phosphorus is inert sulphur, which again is a harmless and normal constituent of the body. As an added point, the beta radiation given off by  $P_{32}$  is of relatively limited penetration, so that it exerts its injurious effect on tissues in close proximity to the region of its absorption.

Regardless of the means of administration and the chemical form in which given, all radioactive isotopes produce their physiologic effects through ionization of protoplasm. This ionization probably is effective through disruption of enzyme systems. Cells are injured in several ways. A vital portion of the nucleus may be damaged with cell death resulting; chromosomal alterations may be induced that show no effect in that cell itself but will be apparent in abnormalities of descendants of that cell; alteration in cellular function may be produced. Alterations of function only are not of primary importance in the tumor cells themselves, but may be very important if they effect the fibroblasts adjacent to the tumor.

One result of irradiation of fibrous tissue cells is the production of an abundance of intercellular collagen with hyalinization of that collagen. This is one of the important effects of radium or x-ray in the treatment of tumors. Not only do they directly damage the tumor cells but also they induce local fibrosis by the supporting cells of the tumor which hampers the spread of the tumor and interferes with nutrition except by the tumor cells. Similarly, damage may be done to blood vessels carrying nourishment to the tumor.

Radioactive iodine has been found to be useful in the therapy of certain disorders of the thyroid gland because of the avidity with which the thyroid picks up iodine. Thus, it has been possible to concentrate radioactive iodine by selective absorption in the hyperplastic thyroid gland and in certain tumors of the thyroid and their metastases. Deposited there, irradiation of the thyroid cells ensues, with regression of their hyperactivity, at least for a time.

In the case of sodium, on the other hand, there has been relatively little therapeutic use, because the high diffusibility of sodium and the absence of selective absorption of it by body cells has given it no advantages in therapy over the administration of total body radiation.

While the therapeutic value of numerous other radioactive isotopes remains to be explored, it is probable the chief value of these new substances lies in their use as tracer substances to facilitate research.

In the therapy their value is limited by the relative infrequency of diseases for which they are effective, by the need for detailed control of their use by physicists as well as medical men, and by the steady loss of radioactivity that makes storage and distribution costly and difficult.

The aim of the tracer technique is to use the radioactive material in too small an amount to have cellular alterations induced by the radioactivity, but to use that activity, as determined by a highly sensitive instrument such as the Geiger Counter, to follow through the body the movements of the particular molecules containing the tracer substance. By the appropriate selection of isotopes it is possible to tag and trace more than one of the atoms incorporated into a given molecule. Thus, by using radioactive zinc in protamine zinc insulin, it is possible to follow the distribution of the zinc insulin complex until it has been split off from the molecule.

By feeding minute amounts of radioactive iron it has been possible to make the hemoglobin of red blood cells radioactive so that the period of survival of transfused red blood cells may be accurately determined. This was of major use in the development of ACD solution that made possible the shipments of large amounts of whole blood from this country to our battlefronts in Europe and the Pacific.

By combining radioactive carbon in the molecule of glucose, it has been possible to make important advances in our understanding of carbohydrate metabolism in the body.

These few examples will perhaps suffice to indicate what a wide and startling range of biologic research has been opened by these substances. The incorporation of suitable radioactive elements in hormones, in vitamins, in drugs, as well as specific foods will permit a far greater knowledge to be obtained of their distribution in the body and the mechanism of their action than could have been attained by any other method.

## STATE PLANNING FOR RURAL MEDICAL SERVICES

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RURAL HEALTH is of vital concern to the American Medical Association. To this end a National Committee on Rural Medical Service has been formed. Each member of the committee has been given a region for which he is responsible. My area is New England, Pennsylvania, New York, New Jersey and Delaware.

The farmer of today is concerned over the conditions of health in rural areas. With this concern there has come a determination to do something constructive about it. In many cases he knows what constitutes good medical care, and he sees no reason why he cannot get it. At the Second Annual National Conference on Rural Health which was held in Chicago in February of this year, it was pointed out by some that the farmer is anxious to cooperate with organized medicine to obtain better medical care, but they also warned that if cooperation was not forthcoming on our part, they would be forced to turn to some other form of medicine, presumably federally controlled. In this day and age it is refreshing to find a group which is anxious to work with us to form a voluntary health plan.

It is quite true that our states do not have the rural problems that we find in the less populous states of the west, middle west, and south, but the farmer who lives outside our cities and finds himself unable to get what he wants and considers to be his due in the matter of good medical care, feels he is just as important as his counterpart who lives many miles from a city. It is further important that medicine present a common front of interest in the affairs of the rural resident. If each state is working actively to improve the lot of the farmer, it will be much easier to gain the support and confidence of the farm leaders. Medicine needs all the friends possible in the next

few years, and this seems an easy way to gain some influential ones.

I feel that the most important task which confronts us in New England is one of educating the farmer as to how he can take steps to improve his health situation. In many instances this may merely mean pointing out to him the way in which he can utilize the health facilities already available to him such as well child conferences, periodic health check-ups, and an aggressive health department. They must be shown that a good doctor asks more from a town than just a place to live. He wants good schools for his children, and good roads so that he may improve his skill at reasonably distanced clinics. The doctor of today cannot long remain happy if he is unable to treat his own patients in a hospital. This need not be large or specialized, but could conceivably be a small unit run in cooperation with a much larger hospital, and staffed by the latter. It may not be economical to run a small health unit, but it may pay high in health dividends. The doctor cannot long remain in a locality where it is commonplace to drive to the city for ordinary medical care, using the physician for emergencies. But even if a town cannot support a doctor, there are many ways in which the health situation can be improved. For example, a town health nurse can do a great deal in this direction, by taking over the situation until a doctor can be obtained, and in following out his instructions between visits which in many cases can be limited because of her help. Home nursing instruction to interested mothers along with first aid instruction has undoubtedly saved many lives.

As I have said above, I feel that the problem of Rural Health in New England resolves itself into one of education. In line with this reasoning, we in Connecticut are planning a Conference on Rural Health to be held at our State University on July 16. We feel that the best way to make this a success would be to have a committee made up of representatives of those organizations which are in any



way interested in rural health. We plan, for example, to have a representative from the State Health Department, the Connecticut Cancer Society, the Yale School of Medicine, the American Farm Bureau Federation, the National Grange, the Agriculture Extension Service, and the P.T.A. The day will be devoted to short talks on just what constitutes good medical care, and what can be done to attain the goal. Each interested group in the state will send delegates. This sort of thing can be a potent force for better health. It is hoped that the conference will lead the way to appropriate action.

The Second Annual National Conference on Rural Health, which was sparsely populated with New Englanders, was held in Chicago in February. This was well attended, and believe me, these farm people are more than anxious to do something constructive about health. I do not think that we can work in real close harmony until many such conferences are held, and we learn to trust each other without reservation. Those attending brought out many good points for the most part, and there were just enough radicals to show that the conference was not rigged in favor of the A.M.A. The inclusion of the more radical people tended to show that we wanted everyone to have some say in the matter, and seemed to be an advantage instead of a detriment.

As a direct outgrowth of the conference the National Committee is urging the formation of a Health Council on a County or Trading Area basis. The county may in some instances not represent the proper subdivision of a given territory for many people are grouped together by the habit of trading in a particular town or city. If this is the case, it would be foolish to attempt to organize them on the county level. There are some states which may find it more practical to form only a state council. This might happen in a state small in area or population. There should be a state council in every instance, but the real work should be done by the smaller units.

A Health Council seems to be the logical outgrowth of the now diversified efforts of the many groups who are wholly interested in health or only partially interested. In too many instances their work overlaps with a consequent loss of efficiency. The American Red Cross carries on quite a few activities in the health field such as home nursing courses, first aid, and so forth. The Parent Teacher Association has been instrumental in obtaining hot lunches for the school children, and aids in arranging preschool health examinations.

The National Tuberculosis Association has been disseminating information on tuberculosis, and doing much to prevent its spread. The Cancer Society, the Boy Scouts, national farm organizations, and even some of the secret ritualistic organizations are all interested in health in one way or another. If all these agencies together with the health department in each area could be coordinated into a Health Council, it would make for a potent group under unified control without any overlapping of functions or wasted effort such as is seen today. The more individual groups which can be interested in such a plan, the more potent the Council will be. Such a body will be a powerful agency in the dissemination of sound health ideas.

I hope that each state in the country will appoint a Committee on Rural Medical Service as a means of keeping in touch with the situation, and to act where action is necessary.

It seems to me that rural health is of deep concern to all of us. It is not a question of being idealistic about the plight of the farmer, but it is more of a question of making friends when every friend counts. We cannot do the whole thing alone. Indeed, the people involved must do it. We can only point the way. As I said recently to a farm group, "You must first wish for better things, and then turn the wishing into willing. In that way and in that way alone will you be able to obtain the improvement in your health situation which we are all seeking."

## MALARIA COMPLICATING APPENDICITIS — A CASE REPORT

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THE NUMBER of veterans of World War II who may return to civilian life harbouring a latent malarial infection is unknown. According to a recent issue of the Veterans Administration *Information Bulletin*: "At this date there is good reason to believe that, in a large portion of returned overseas veterans, relapses have already ceased to occur and with each passing month it becomes less likely that the symptoms for which they seek treatment will be due to malaria." According to Bass,<sup>2</sup> mental or physical strain or trauma may precipitate acute malarial attacks in infected individuals who have escaped recognized clinical symptoms for many months. The following case report is therefore submitted, along with a brief discussion, in that it presents a somewhat unusual combination of diseases as seen in New England in the past, but one which may be repeated.

W. R. a 24 year old white male veteran was admitted to the Lawrence & Memorial Associated Hospitals at 10 P. M. on January 1, 1947. He complained of abdominal pain of ten hours' duration which had gradually become most intense in the right lower quadrant. There had been no vomiting or diarrhea, but nausea, anorexia, and a "chilly sensation" were present.

One month previous, while on a honeymoon in New York, he had experienced a similar attack, and was admitted to a hospital. It was thought at first that his symptoms were due to appendicitis, but further examination disclosed that his temperature had risen to 106°, and there were malarial parasites present in the blood stream. He was treated with quinine, made an uneventful recovery, and was discharged on the 6th hospital day with a diagnosis of "Malaria type undetermined, acute recurrent."<sup>3</sup>

Further questioning disclosed that in August 1943, he had had one attack of malaria in the South West Pacific area. Thereafter he took atabrine until his return to the United States in July 1945, and had no further attacks. Since his return he has been living in Connecticut taking no medication.

On admission, physical examination revealed a well developed, white male who appeared acutely ill. Temperature was 102.4 degrees per rectum, pulse 100, respirations 20. The skin was pale, no jaundice present, positive physical findings being limited to the abdomen. The entire lower abdomen showed muscle spasm and tenderness which was most marked in the right lower quadrant. He was also tender in the left upper quadrant. The spleen could not be felt. The rectum

was empty and no localized tenderness or masses could be made out on digital examination.

Laboratory examinations revealed no parasites in a blood smear for malaria, and a W.B.C. count of 14,500 with 80 per cent polymorphonuclear cells of which 7 were non segmented. The urine was negative.

In view of his recent history quinine was administered in 10 grain doses every six hours, and patient was observed for ten hours, during which time he appeared more comfortable, temperature fell to 100 degrees, and he took and retained clear fluids well. However, the W.B.C. count rose to 16,000, with 88 per cent polymorphonuclear of which ten were non segmented. It was felt that further temporizing carried more risk than operation, and an appendectomy was performed under spinal anesthesia. The appendix was encountered lying over the brim of the pelvis in a small, well walled off cavity containing free pus. Pathological diagnosis was "gangrenous appendicitis with perforation." The abdomen was closed without drainage, although a small wick drain was placed beneath the fascia in the abdominal wound.

Repeated blood smears made the following day revealed the presence of plasmodium vivax. Culture from the abdominal cavity grew *B. coli* in pure growth.

The patient made a quick and uneventful recovery, complicated only by an upper respiratory infection developing on the sixth day. A full course of the therapeutic atabrine treatment, as advocated by the U. S. Navy, was begun on the third postoperative day. The patient left the hospital fourteen days after admission and has been followed for the past two months, during which time he has been symptom free.

In conclusion, there is no doubt that if this man had not had his history of malaria, with recovery from abdominal pain following quinine a month previously, the diagnosis of an acute surgical abdomen would have been fairly obvious. The patient quoted the attending surgeon in New York as saying, "If I didn't know you had malaria, I would stake my reputation that you had acute appendicitis." From the appearance of the pathology found at the operation, it seems fairly certain that he did, in fact, have appendicitis at this time.

During the writer's service in the U. S. Naval Reserve in this war, several cases of malaria were seen in which abdominal pain and tenderness were prominent symptoms, although none were encountered with marked muscle spasm. In view of the



extremely well localized small abscess about the appendix, it may be suspected that perforation occurred during the attack a month previously, although at that time it was good judgment to defer surgery, in view of the extremely high temperature and rapid improvement under quinine therapy. It should be borne in mind however, that malarial involvement of every viscus can occur, sometimes producing bizarre symptoms, and a latent malaria is

apt to flare up during lowered resistance due to trauma or acute illness, producing a complicated diagnostic problem.

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## CANCER OF THE FACE — REMARKS ON PRESENT DAY TREATMENT

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THE PRESENT treatment of facial cancer at the Skin and Cancer Unit of the New York Post-Graduate Medical School and Hospital is based on the principles of radical surgery as put forth over thirty years ago by the late Drs. George H. Semken and Franz Torek. These principles are now being generally accepted in the contemporary phase of cancer therapy.

The practical application of the knowledge gained in physiology and chemotherapy have contributed materially to making the patient safe for the operative procedures, and coupled with the improvements in surgical technique and the knowledge of surgical pathology, have lowered the morbidity and mortality in all surgery. The mortality for example in radical mastectomy and neck dissections has fallen from 15 per cent to about 1 per cent. The improvements in anesthesia have permitted extended operability and enable the surgeon to make a careful, time consuming, anatomical dissection, often required to perform a radical operation for cancer including tri-dimensional local excision and removal of the regional lymph nodes and lymph bearing areas necessary to eradicate the disease and to prevent regional metastases.

In early cases of face cancer<sup>1</sup> a simple but wide excision of the tumor with careful approximation of the skin edges and early removal of the sutures

not only arrests the disease but gives a satisfactory cosmetic result especially if taking advantage of the natural skin folds. In the more advanced lesions not involving cartilage or bone, radiation may control the growth but a tendency toward prolonged convalescence and an undesirable cosmetic end result with telangectatic and atrophic skin as well as an increased incidence of recurrences leads us to this other phase of cancer therapy: surgery. Radiation therapy is still indicated in the highly malignant retro-pharyngeal tumors, tumors of the hemopoetic system including lymphosarcoma, Hodgkin's Disease, and some malignancies of bone. It is also of value in palliative treatment of inoperable malignancies.

From a practical viewpoint basal cell carcinoma, squamous cell carcinoma, and mixed baso-squamous cell carcinoma of the skin of the face are all treated in the same manner with a tri-dimensional local excision;<sup>4</sup> as the squamous and mixed baso-squamous types seldom form metastases until late in the disease process, and these are very rare in basal cell cancer. A simple but wide excision under 1 per cent procaine block anesthesia is sufficient to cure the patient in most cases. In the patients operated upon in the Skin and Cancer Unit of the New York Post-Graduate Hospital, the defect is closed by a full thickness graft or preferably, by a skin flap from the neighboring tissues because of color and texture. Thiersch-Ollier split grafts are unsatisfactory on the face from a cosmetic point of view.

Squamous cell carcinoma of the lip<sup>6</sup> or ear<sup>1</sup> and within the oral cavity<sup>7</sup> frequently form metastases to the regional lymph nodes and therefore a prophy-

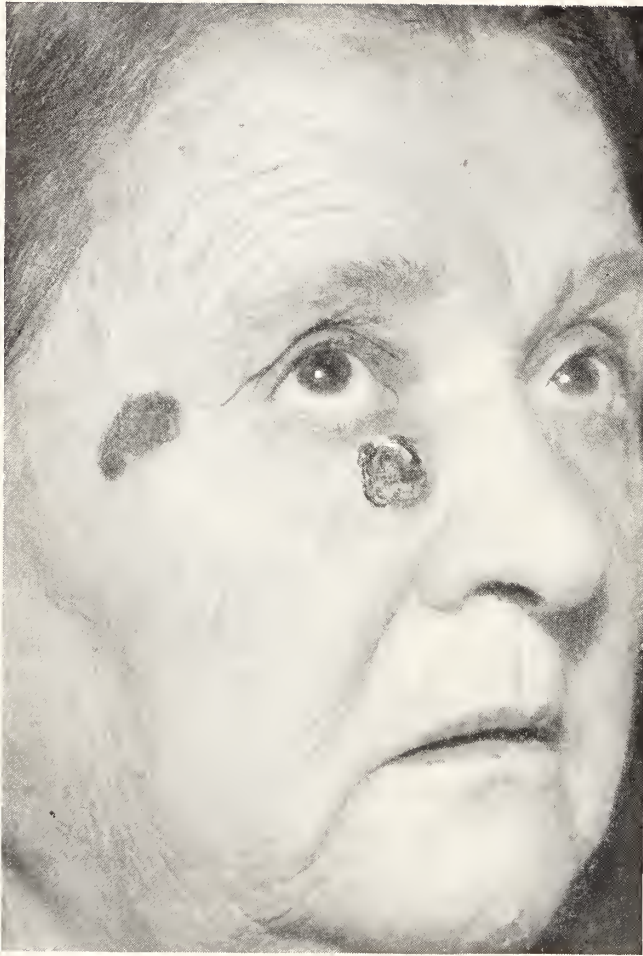


FIGURE 1 (a)

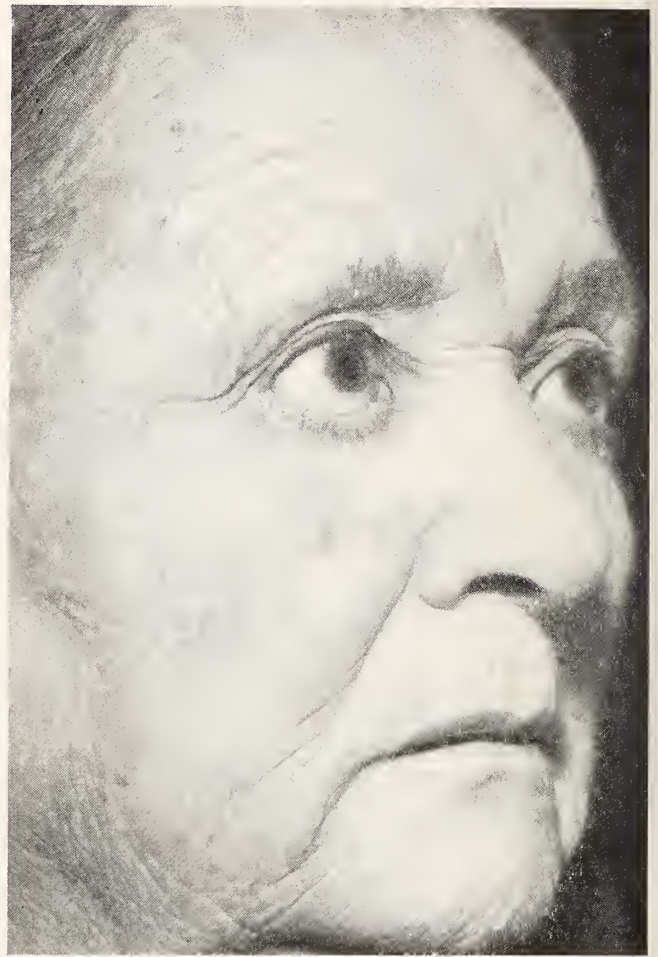


FIGURE 1 (b)

Basal cell carcinoma of the infraorbital region and senile keratosis of the temporal region. (a) Before treatment; (b) After excision and full thickness graft. The keratotic area was treated electrodesiccation well over five years.

lactic dissection of the lymphatic bearing areas is practised even in the absence of palpable lymph nodes. With palpable lymph nodes present, a more radical excision of the lymphatic drainage area is recommended to improve the chances of cure. Radiation therapy is seldom of value in the treatment of neck metastases. (Fig. 2).

Malignant melanoma of the face has a better prognosis and a higher cure rate than malignant melanoma of the extremities when treated by wide excision of the tumor with excision of the drainage area and lymph nodes in continuity<sup>5</sup>.

In selected cases of advanced cancer of the face, the palliative effect of electro-surgery may improve the local condition or may arrest the disease for many years.<sup>4</sup> The electro-coagulation is of value in recurrent cases in which scar tissue and the ill defined penetration of the recurrent tumor adds to

the difficulties of the determination of its extent. With such technique the tumor is destroyed and the surgeon may follow its infiltration until normal surrounding tissues are reached. Then with the excision of the "tumor bed" the surgeon not only eliminates the diseased tissues but also assures against further recurrences<sup>2,3,4</sup>.

Studying over 1000 patients applying to the Skin and Cancer Unit, it has been found that on an average there is a year's delay with the basal cell cancer from the time it is first noticed by the patient until it is seen at the clinic. In the case of squamous cell carcinoma the elapse of time is about 3 months. Analysis of such delays in consultation shows that 75 per cent of the cases are due to a lack of knowledge or fear on the part of the patient, and that in 25 per cent of the cases the patient consulted a physician who either failed to recognize the lesion or else



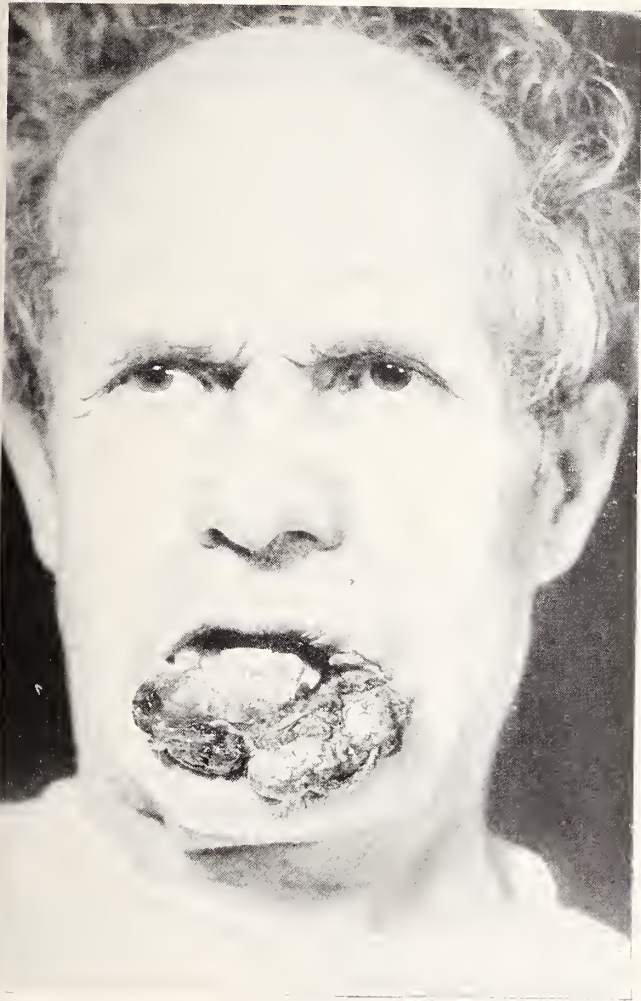


FIGURE 1 (a)

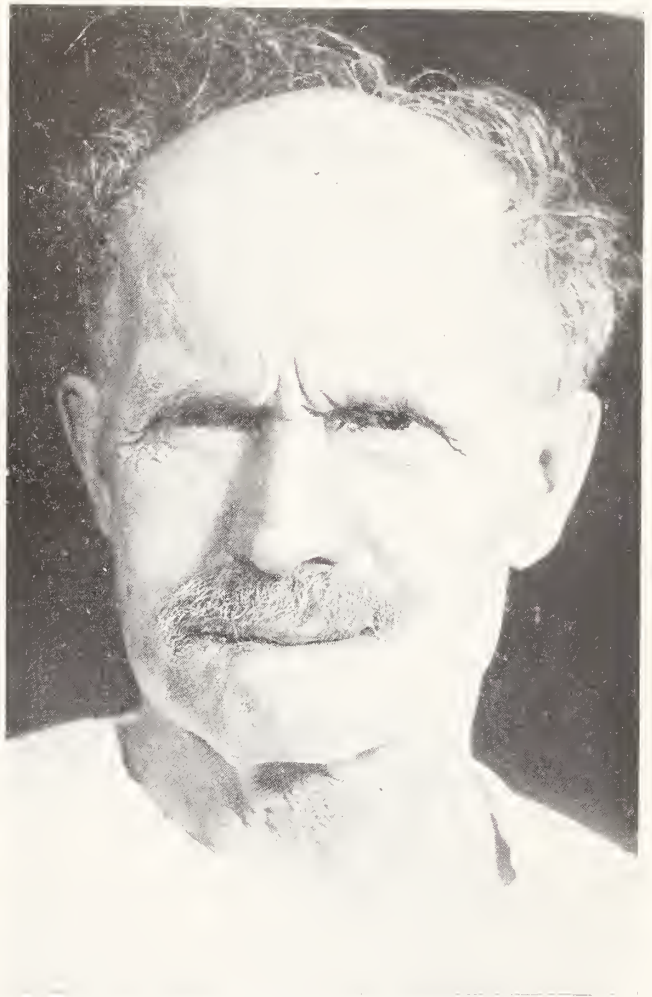


FIGURE 1 (b)

Exuberant proliferative type of squamous cell carcinoma of lip about three years duration. (a) Before; (b) After operation and one stage repair. Well after five years.

shows that 20 per cent of the patients had recurrent lesions which had received inadequate treatment elsewhere. Among patients with recurrences there was a recurrence rate of 10 per cent as a result of inadequate surgical excision while the rate 48 per cent in those treated with irradiation and 32 per cent in those treated with the "electric needle" and other methods.

#### RESULTS OF TREATMENT BY WIDE SURGICAL EXCISION

Among those patients operated and with a complete follow-up, there were 229 cases of early primary basal cell carcinoma of the face treated by wide radical local excision. Of these there were 227 (99 per cent) free of the disease at the end of five years. In 81 cases of recurrent basal cell face carcinoma, there were 71 (87.7 per cent) patients free of the disease at the end of five years. There were no operative mortalities in this series.

Primary squamous cell and mixed baso-squamous cell cancer of the face showed a five year arrest in 87.5 per cent of the patients operated with one operative mortality.

Malignant melanoma of the face gave a 42.3 per cent five year arrest and 19.2 per cent ten year arrest in the 26 patients treated by radical surgery without any operative mortality.<sup>5</sup>

#### SUMMARY

1. The present treatment of basal cell, squamous cell, and mixed baso-squamous cell carcinoma of the face is radical local excision.
2. The treatment for squamous cell carcinoma of the ear, lip, or intra oral cavity is wide local excision with removal of the lymph bearing areas whether nodes are palpable or not.
3. The treatment of malignant melanoma of the





The “physical demands analysis” is the accumula-

By comparing the physical activities the prospec-

	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36	37	38	39	40	41	42	43	44	45	46	47	48	49	50	51	52		
NOTE: PLACE A CHECK (✓) IN EACH BOX DESCRIBING AN ACTIVITY THE EMPLOYEE IS NOT CAPABLE OF DOING UNDER NORMAL, HEAVY WORK CONDITIONS	100% STANDING	PARTIAL STANDING	100% WALKING	MUCH WALKING	MUCH TALKING	ANY KNEELING	ANY STOOPING	ANY CLIMBING	MUCH PULLING	MUCH PUSHING	NIMBLE USE OF FINGERS	USE OF BOTH HANDS	USE OF RIGHT HAND AND PARTIAL USE OF LEFT	USE OF LEFT HAND AND PARTIAL USE OF RIGHT	USE OF RIGHT HAND	USE OF LEFT HAND	RAISING RIGHT ARM ABOVE SHOULDER	RAISING LEFT ARM ABOVE SHOULDER	LIFTING FROM 10-25 LBS	LIFTING OVER 25 LBS						GODD(20/40 & 14/28)	FAIR(20/60 & 14/42)	POOR		GODD(20/10)	FAIR(20/5)	POOR	HOT	COLOR	WET	HUMID	SIPPING OR TRIPPING CONDITIONS	DUSTY	FUMES	NOISY	OUTDOORS	SEASON OUTDOORS	ANY SKIN IRRITANTS				POOR COORDINATION	NERVOUS INSTABILITY	FAINTING OR DIZZY SPELLS	IS HE A DEAF-MUTE	IS HE ONE LEGGED	IS HE ONE ARMED	IS HE BLIND	
	IS APPLICANT INCAPABLE OF ?																								VISION CORRECTED?		HEARING?		IS THE APPLICANT INCAPABLE OF WORKING UNDER THESE CONDITIONS ?																								DOES THE APPLICANT HAVE ?	
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tive worker is not capable of doing with the physical requirements demanded by the job the placement officer is readily able to determine whether or not the disabled veteran is physically qualified to perform the job successfully.

The employment officer compares the physical abilities of the disabled veteran with the physical requirements of the jobs analyzed and makes his decision relative to the occupational classification of the applicant based on qualifications.

The process of Selective Placement is necessary to proper placement, which requires that the remaining physical abilities of the disabled veteran be matched with the physical demands of jobs for which he is otherwise qualified so that, (1) the disabled veteran can meet the physical demands of the job, (2) the job does not present a hazard to the worker, (3) the safety of others is not placed in jeopardy, and (4) the job should not aggravate the disability.

Proper placement is essential to good performance on the job as it relates to efficiency and productivity, absenteeism, tardiness, second injuries, and stability. An employer is in business for profit—that is his main objective. His immediate problem is constantly that of maximum production and quality at minimum cost, if he is to maintain and improve his competitive standing among other employers who are also after a share of the consumer's dollars.

In the attainment of this objective the employer must not only undertake solution of problems such as the prevailing market, raw materials, technological changes, time studies, plant lay-out and others, but also the vast and intricate problems of personnel administration—problems which directly affect the worker. His primary objective (profit) demands that he also consider problems of personnel such as efficiency, tardiness, absenteeism, labor turnover, industrial accidents, and other personnel factors harmful to his efforts to maintain maximum production and quality at minimum cost.

Proper placement of disabled veterans through the Selective Placement process will go far to insure *good performance on the job*—a requisite in the interest of increasing job opportunities for other disabled veterans. Various surveys have been made by the Bureau of Labor Statistics, U. S. Department of Labor to determine the performance history of properly placed disabled workers in industry. One study involved 300 employers who had 63,382 disabled workers on their payrolls. The resulting data

## *A Study of*

**300 EMPLOYERS — 63,382 Disabled Workers\***

### **EFFICIENCY**

7.8% of the disabled were more efficient than the able-bodied.  
87.2% of the disabled were as efficient as the able-bodied.  
5.0% of the disabled were less efficient than the able-bodied.

### **ABSENTEEISM**

49.0% of the disabled were absent less than the able-bodied.  
43.8% of the disabled were absent as much as the able-bodied.  
7.2% of the disabled were absent more than the able-bodied.

### **INJURY**

51.1% of the disabled were injured less frequently than the able-bodied.  
37.7% of the disabled were injured as frequently as the able-bodied.  
11.2% of the disabled were injured more frequently than the able-bodied.

### **TURNOVER**

58.5% of the disabled stayed on their jobs longer than the able-bodied.  
30.8% of the disabled stayed on their jobs as long as the able-bodied.  
10.7% of the disabled did not stay on the jobs as long as the able-bodied.

illustrated below indicates that the handicapped worker when properly placed can be expected to be as good as, or better than, the able bodied worker.

Selective Placement makes possible the integration of disabled veterans with the normal labor market. It makes possible their ability to openly compete with able bodied workers for certain jobs. Their performance records as exemplified above are conducive to employer willingness to view the disabled veteran as a worker with abilities. As a result more and more employment opportunities are being made available to disabled veterans, making them self-sufficient and economically independent.

Experience has shown, however, that there is a need for informational programs whereby pertinent information relating to the principles of Selective Placement is disseminated to doctors. When confronted with the task of completing a Physical Capacities Appraisal, many doctors are confused and in most cases return the form containing no information other than the generic name of the disability. Of course, for employment service purposes the generic name of the disability is of little value compared to what is really wanted; namely, a *translation*



*of medical information into terms of ability to engage in physical activities comparable in terminology to the information obtained in the physical demands analysis.*

These properly prepared appraisals of the disabled veteran's physical capacities are of extreme value in the matching process. They constitute one-third of the Selective Placement process and the key to understanding the disabled veteran's physical ability to perform occupational tasks for which he is otherwise qualified.

Many times doctors are at a loss since they don't feel qualified to recommend jobs that disabled veterans can perform. The Employment Service points out that doctors are not expected to recommend jobs which disabled veterans can perform but are expected to translate scientific medical information into terms of employment as such information is charted on the Physical Capacities Appraisal. The decision as to the worker's physical ability to perform specific jobs rests with the person who is

going to do the overall matching of the disabled veteran with the job or jobs in question.

There is no doubt that doctors play an important role in the Selective Placement process. They make the process *possible* in many cases. Without the Physical Capacities Appraisal the picture is incomplete and much harm can be done to the disabled veteran if any of the four principles of proper placement are observed on a guesswork basis. Further, the employment of disabled veterans is delayed when physical capacity information is unavailable or meager. It is important that this information be complete and in terms of physical activities depicting the true remaining abilities of disabled veterans.

The nature of the problem unquestionably requires that the Connecticut State Medical Society concern itself with the program of Selective Placement for disabled veterans and assist the Connecticut State Employment Service and the Veterans Employment Service in their efforts to place disabled veterans in occupations for which they are qualified.

## CONNECTICUT AND THE FOUNDING OF THE AMERICAN MEDICAL ASSOCIATION

STANLEY B. WELD, M.D., *Hartford*

THE JOURNEY from various points in Connecticut to New York City was a formidable one a century ago. From Hartford it was possible to reach New Haven by rail as this road had been operating since December 1844 with trains running at the enviable speed of 20 miles an hour. From New Haven the journey must be completed by stage or by boat. From the region of New London and Norwich it was possible to reach the latter city via the Worcester and Norwich Railroad, thence by stage to Stonington where a boat trip to New York City completed the journey. In Fairfield and Litchfield Counties railroads ran from Danbury to Norwalk and from Canaan to Bridgeport and steamboat from the latter city to New York. Not until 1848 do we find the New York and New Haven Railroad operating three accommodation trains and one express train, the latter stopping at Bridgeport, Norwalk, Stamford and New Rochelle. These were days before the introduction of dining cars and oil lamps,

although sleeping cars were operating on the Pennsylvania Railroad at the time. A picture of the sleeper of that era is a far cry from the present luxurious equipment of Pennsylvania's Broadway Limited. The car was divided into four compartments, each equipped with three "bunks." In the rear of the car was a towel, a wash basin, and a bucket of water. No bed clothing was furnished, the light came from candles and the heat from box stoves burning wood or sometimes coal. The trains entered New York over the New York and Harlem Railroad, with the cars cut off at 45th Street and coasting down Murray Hill to the station under hand brake control or hauled by horses from 42nd Street to the terminus at Canal Street. Rail travel had its catastrophes then as now, as may be seen by the account of the accident at Norwalk on May 6, 1853, when a train fell through an open drawbridge into the Norwalk River. Forty-four passengers were drowned including seven physicians

returning home from the 6th annual meeting of the American Medical Association in New York City.\*

The first meeting of the National Medical Convention, the forerunner of the American Medical Association, was convened in New York City in May 1846. When Dr. Luther Ticknor, a native of Vermont and at that time practising in Salisbury, Connecticut, first learned that a national medical association was proposed he wrote to the *Journal of Medicine*, then edited by his friend and brother, Dr. C. A. Lee of New York, earnestly advocating such an organization. He also wrote to Josiah Beckwith of Litchfield, asking his advice about calling an "extraordinary meeting" of the State Society to appoint delegates to the first convention of the National Association. Dr. Ticknor was a man of indomitable perseverance, intent on progress. He not only held many offices in the Connecticut Medical Society, including that of president at the time of his death, but represented his town at two sessions of the State legislature. Dr. Fishbein in his History of the American Medical Association credits Dr. Ticknor with correspondence with Dr. Nathan Smith Davis of New York, one of the prime movers in the first organization meeting and a leader in The American Medical Association for years to come. As Dr. Fishbein has so astutely pointed out: "One is constantly amazed at the remarkable talent for organizational efficiency and the supreme qualities of leadership manifested by Nathan Smith Davis in the first forty years of the work of the American Medical Association. If ever it could be said that one man more than any other deserved credit for having inspired the necessary cooperation for advancement, for having manifested ingenuity of thought and action, for having worked with indomitable courage and energy for the advancement of an organization, that credit should go to Dr. Nathan Smith Davis." Doubtless we should have found Luther Ticknor prominent in that memorable first meeting had not death taken him on April 19, one month previously.

The first meeting of the National Medical Convention assembled in the building of the Medical Department of the University of the City of New York on May 5, 1846 at the call of the New York State Medical Society. The manner of appointment of delegates was somewhat confused by two conflicting resolutions passed on successive years by the

New York Society. The first called for the appointment of delegates "from Medical Societies and Colleges in the whole Union," the second "did not contemplate the appointment of Delegates . . . by County or merely local Societies in those States where delegates are appointed by a regularly organized State Society." The result was a reporting "of all gentlemen from Medical Societies, Colleges and Institutions of all the States who come properly accredited," leaving the decision up to the Convention as to whether or not these shall constitute the National Medical Convention. This latter broader basis was adopted for official membership in the Convention.

Connecticut sent nine of her distinguished physicians as delegates to New York City in May 1846. Most of them were prominent in medical affairs at home. V. M. Dow of New Haven, Rufus Blakeman of Greenfield, William H. Cogswell of Plainfield, Josiah G. Beckwith of Litchfield, Eleazur Hunt of Hartford, D. T. Brainard of New London, and Richard Warner of Cromwell represented The Connecticut Medical Society. The Medical Institute of Yale College selected Eli Ives and Jonathan Knight. The minutes of the convention record that George Sumner of Hartford, "a delegate from the Medical Society of Connecticut," was also received.

The outstanding individual of this group without any doubt was Jonathan Knight, an active teacher at Yale for 51 years. He appears first as a member of the committee of one from each State represented to nominate officers for the Convention. This committee unanimously selected Dr. Knight as the first president. Much has been written of this distinguished gentleman who always appeared in public clad in dress coat and faultless white tie. Descendent of a line of physicians, he entered Yale College at the youthful age of 15. He became eminently successful as a practitioner and a teacher, filling successively the chairs of professor of physiology and anatomy and of surgery at the Medical Institute of Yale College. He was twice president of the American Medical Association and the manner in which he presided is said to have been the subject of such universal admiration that he was very often selected to preside over meetings of the Committee of the Whole. His success as a presiding officer lay in the use of common sense rather than in a knowledge of parliamentary rules. In 1838 Dr. Knight was the leading surgeon in Connecticut. It is not difficult to picture this man of calm dignity and mild radi-

\*Connecticut delegates drowned were Archibald Welch and Samuel Beach



ance standing before his colleagues at that first convention, conservative, yet possessing opinions of his own. He bore his honors modestly as became the thorough student that he was. Connecticut may be justly proud of Jonathan Knight.

One of the first resolutions introduced pertained to medical education. On the committee of nine appointed to bring this subject before the Convention we find Connecticut represented by D. T. Brainard of New London. A resolution was also introduced that a "committee of seven be appointed to report a plan of organization for such an Association at a meeting to be held in Philadelphia on the first Wednesday in May 1847." The name of W. H. Cogswell of Plainfield appears on this important committee. William Henry Cogswell was Windham County's most prominent physician of that day. He later served the State Society as its president for two consecutive years. A kindly man with a deep sense of honor, temperate, prudent, patriotic, he was rewarded during the Civil War by receiving from Governor Buckingham a special commission to visit the sick and wounded Connecticut soldiers in U. S. Military hospitals. He appeared twice as a member of the State Legislature, in 1830 in the House and in 1860 in the Senate.

A third resolution called for a committee of seven "to prepare and issue and address to differently regularly organized Medical Societies and chartered Medical Schools in the United States setting forth the objects of the National Medical Association and inviting them to send delegates to a convention to be held in Philadelphia on the first Wednesday in May 1847." To this committee were appointed two New Haven physicians, Eli Ives and V. M. Dow, and George Sumner of Hartford. One of these gentlemen, Dr. Ives, has left an enviable record. Like Jonathan Knight he was a prominent member of the faculty of The Medical Institute of Yale College, holding in succession the chairs of professor of materia medica, professor of theory and practice of medicine, and again professor of materia medica. He was active in the New Haven County Medical Association and secretary of the State Society from 1810-1812. His fame as a botanist reached beyond the border of Connecticut and he is reputed to have gained a knowledge of the medical uses of native plants which was believed to be unequalled in his day. With a smothered voice, rambling all over the field in his lectures, he must have created some amusement for his students as he stood there plying

his uncommonly large deviated nose with great pinches of snuff, much of which, it is rumored, lodged in the folds of his waistcoat. Yet he inspired confidence in his patients, so great that it required three horses to serve his needs of transportation over the countryside. The American Medical Association honored Dr. Ives by electing him president in 1861.

The question of a satisfactory premedical education came before this first convention and a resolution was passed, to wit, "that it is desirable that young men, before being received as students of medicine, should have acquired a suitable preliminary education and that a Committee of Seven be appointed . . . to report at the meeting to be held on the first Wednesday in May 1847." We find D. T. Brainard of New London serving on this committee also.

Of far reaching effect was a resolution then introduced, "that the Union of the business of Teaching and Licensing in the same hands is wrong in principle and liable to great abuse in practice. Instead of conferring the right to license on Medical Colleges and State and County Medical Societies, it should be restricted to one Board in each State, composed in fair proportion of representatives from its Medical Colleges and the Profession at large, and the pay for whose services as Examiners should in no degree depend on the number licensed by them." Dr. George Sumner of Hartford, as was his custom, moved to lay this resolution on the table but later thought better of his action and withdrew the motion. The reference committee of seven which considered this resolution brought in a lengthy report. Connecticut's representative on this committee was Rufus Blakeman of Greenfield. As a member of the Committee of Examination of the Connecticut Medical Society for seven years, Dr. Blakeman must have been eminently qualified for this task, but for some unknown reason he did not sign the committee's report. Rufus Blakeman was an outstanding member of the profession and the author of a book entitled "A Philosophical Essay on Credulity and Superstition," published in 1849. In 1851 he was president of his State Society and, like many of his contemporaries, took an active interest in local politics, representing the town of Fairfield in the legislature and serving for several years as Judge of Probate. He must have possessed more than an average interest in biographical history as his presidential address sketches the lives of the early practitioners

of Fairfield County.

Among the other Connecticut physicians who were present at this first National Convention was the colorful Josiah G. Beckwith of Litchfield. He was destined to guide the fortunes of the Connecticut Medical Society through those war years of 1862 and 1863. At its annual meeting in Bridgeport in 1862 he addressed the Society on "Medical Progress" and the following year in Rockville on "The Medical Profession—Its Dignity and Grandeur." It was this same Josiah Beckwith who in his presidential address of 1862 spoke these words: "This year has witnessed the transformation of a peaceful people, devoting their energies to the cultivation of the soil, to manufactures and commerce, into the greatest military power on the earth; the pursuits of husbandry have been interrupted by the march of great armies, and the hum of the wheel and the smoke of the furnace have been lost in the roar of artillery and the cloud of battle." Twice in this twentieth century this statement again has been paralleled.

Eleazur Hunt of Hartford, who had received an honorary degree of M.D. in 1826, was four years clerk of the Hartford County Medical Association and many times a Fellow at the annual meetings of the Connecticut Medical Society. Discriminating, prudent, judicious, Dr. Hunt was remarkably successful in the practice of medicine as distinguished from surgery, and particularly in the treatment of women and children. Another delegate from Connecticut, Richard Warner, was practising in Cromwell at the time of the first National Medical Convention. A native of Hadlyme, he had practised in that town and in Chester and later in East Haddam before moving to Cromwell. Dr. Warner probably was best known for his support of all the moral reforms of his day. A man of strong character, honest and upright, he boasted many warm friends and, as is so often the case, many bitter enemies.

One of the most active and valued members of the Connecticut Medical Society was George Sumner of Hartford. Trinity College in that city has good reason to remember this physician who as professor of botany planned the landscaping of the college grounds. He was a man of sound constitution, vigorous intellect, unexceptionable habits. Active in the founding of the Hartford Retreat, the Hopkins Medical Society, and later the Hartford Medical Society, Dr. Sumner likewise served as clerk of the County Association and on many of

the State Society committees. As president of the latter organization his address on "The Early Physicians of Connecticut" maintains a place of importance in the field of medical biography. A stout man of massive features, "well marked and luminently expressive of benevolence and good sense," with a gait suggesting that of a sailor on shore leave, he showed a singular preference for riding. His practice grew and overtaxed his physical and mental powers, as it has in so many instances, resulting in a premature old age and a comparatively early death.

According to plans laid at the first meeting of the National Medical Convention the second meeting was called in Philadelphia on May 5, 1847. This session was convened in the Academy of National Sciences, and continued through three days. It was at this session that regulations were approved for the actual formation of the American Medical Association. Connecticut was well represented by eleven physicians.\* At the opening session Jonathan Knight's nomination as chairman was unanimously confirmed. Later when the nominating committee, of which Eli Ives was a member, brought in the slate of permanent officers, Dr. Knight was the only candidate for president. Thus he became for the second year president of the National Medical Convention.

One of the first acts of the new president was the appointment of a committee to invite Dr. John Redman Coxe to take a seat upon the floor of the convention. On this committee appears again the name of Eli Ives. George Sumner of Hartford early came into prominence when he offered the following: "Resolved, that a committee of three be appointed to ascertain and report to the next meeting of the Association what legal enactments exist in several states relative to the practice of medicine and also what societies have been formed to advance the medical profession."

At the first evening session of the Philadelphia meeting the real birth of the American Medical Association was accomplished in these words: "Resolved, that this Convention do now resolve itself into the 'American Medical Association' and that

\*From the Medical Institute of Yale College, Jonathan Knight and Eli Ives; from the Connecticut Medical Society, George Sumner, N. B. Ives, B. Fordyce Barker, Elijah Baldwin, Johnson C. Hatch, William B. Casey, Alden Skinner, and Elijah Middlebrook; from the New Haven Medical Association, Ebenezer H. Bishop. Drs. Barker, Baldwin, Casey and Skinner were absent.



the Officers of the Convention continue to act as Officers of the Association until others be appointed." The vote of acceptance was unanimous. With Jonathan Knight serving as the first president the importance of Connecticut's position in the founding of the parent organization received further emphasis. Appreciating the implications of this heritage, the Connecticut State Medical Society has been ever mindful of its obligations. The first act of Dr. Knight as president was the appointment of a committee comprising one member from each State represented at the Convention to nominate officers of the Association for the ensuing year. Dr. N. B. Ives represented Connecticut on this committee and as a result of its deliberations Nathaniel Chapman of Pennsylvania was unanimously chosen president. Also by unanimous consent four vice-presidents were selected, Jonathan Knight, A. H. Stevens of New York, James Moultrie of South Carolina, and A. H. Buchanan of Tennessee. Eli Ives with four others was directed by President Knight to wait upon the president-elect and invite him to take the chair.

Committee business went on apace. Of the standing committees appointed at the Philadelphia session only one, the Committee on Indigenous Botany, carried the name of a Connecticut physician, Eli Ives. But there were many reports from Committees appointed the previous year at the first session of the National Medical Convention. One of these, the report of the Committee on the Organization of a National Medical Association, of which William H. Cogswell was a member, was signed by all except that gentleman. Perhaps this is best explained by the absence of his name from the list of delegates to the 1847 convention. To this committee goes the credit for drawing up the constitution of the American Medical Association. The wording of the preamble is of interest: "Whereas the Medical Convention, held in the city of New York in May, 1846, have declared it expedient 'for the Medical Profession of the United States to institute a National Medical Association';

"Inasmuch as an institution so conducted as to give frequent, united and emphatic expression to the views and aims of the Medical Profession in this country, must at all times have a beneficial influence, and supply more efficient means than have been available here, for cultivating and advancing medical knowledge, for elevating the standard of medical education, for promoting the usefulness, honour,

and interest of the Medical Profession; for enlightening and directing public opinion in regard to the duties, responsibilities and requirements of medical men, for exciting and encouraging emulation and concert of action in the profession, and for facilitating and fostering friendly intercourse between those who are engaged in it;—therefore,

"Be it resolved, in behalf of the Medical Profession of the United States,—that the members of the Medical Convention held in Philadelphia, in May, 1847, and all others who, in pursuit of the objects above-mentioned, are to unite with, or succeed them, constitute a National Medical Association;—and that, for the organization and management of the same, they adopt the following Regulations."

Then follow the six articles of the constitution of the American Medical Association. Besides the title, provision was made for membership, delegates, meetings, officers, eight standing committees, and "equal assessment of not more than \$3.00 annually on each member."

The right of licensure by medical colleges was reported on and from this came a resolution to the effect that "some additional checks to the exercise of this right should be established by the great body of the medical profession." This resolution was referred to one of the new standing committees, that on medical education. A code of medical ethics was brought in at this Philadelphia meeting, in which was discussed the duties of physicians to their patients together with the obligation of patients to their physicians, the duties of physicians to each other and to the profession at large, and the duties of the profession to the public and the obligations of the public to the profession.

Instead of Josiah G. Beckwith, Litchfield County sent Johnson C. Hatch to Philadelphia. About a decade before this meeting Dr. Hatch had been forced to relinquish his practice because of poor health, but after two years in Illinois he returned to Kent, apparently recovered. At one time Dr. Hatch was president of the Litchfield County Society and his name often appeared in the list of Fellows of the State Society. His candor and perfect truthfulness may have accounted for his election to one session of the Legislature and to his position as Judge of Probate which he enjoyed for several years. As previously noted four of the eight delegates from the Connecticut Medical Society did not attend. Last minute emergencies, entirely unforeseen, must have kept away such men as B. Fordyce Barker,

William B. Casey, and Alden Skinner. It was probably another story with Elijah Baldwin. Shortly before the Philadelphia convention Dr. Baldwin, then practising in Central Village, had been obliged to stop work because of severe acute arthritis. For four years he traveled and he was engaged in this health seeking diversion when his name was called on the roll of delegates at Philadelphia. Soon after he retired to the life of a farmer in Canterbury, refusing the appointment of surgeon of the 5th Connecticut Regiment in 1863, but serving as president of the Windham County Medical Society in 1879. Elijah Baldwin was somewhat eccentric in character, yet had a kind word for all. Unlike most physicians of his day, when he died suddenly of chronic nephritis in 1888 he left a large estate to his heirs.

Alden Skinner in 1847 was practising in his native town of Vernon. His biographer believes few men visited more patients in a year than did he. He was a man of an uncommonly strong and vigorous intellect, well read, possessing a large and tenacious memory. A regular attendant at the Tolland County medical meetings, he was most interested in teaching young medical students. He was one of the casualties of war, dying of "malarious typhoid" in New Orleans while a surgeon of the 25th Regiment, Connecticut Volunteers.

It is not surprising, perhaps, that William Casey did not get to Philadelphia in 1847. In addition to his practice in Middletown at that time he was interested in newspaper publishing and later became proprietor and editor of a news daily and then of a weekly publication. Dr. Casey was a versatile man. Besides practising medicine and editing a newspaper, he was twice mayor of Middletown. He served as a surgeon in the Civil War, as a Trustee of the General Hospital for the Insane of the State of Connecticut, and as senior warden of the Church of the Holy Trinity in Middletown.

B. Fordyce Barker at the time of the Philadelphia convention was a resident of Norwich. His absence can probably be explained by his duties as lecturer on obstetrics in Bowdoin Medical School. This must have necessitated spending certain weeks of each year in the little Maine town of Brunswick and conceivably may have required his presence there that first week in May, 1847. Dr. Barker became one of medicine's great men. A native of Maine, a resident of Connecticut for a number of years, he spent the last three decades in New York City where he participated in the organization of the New York

Medical College and occupied the chair of professor of obstetrics and diseases of women and children. He has become best known for his essay, "Puerperal Diseases," published in 1874 and translated into Italian, French and German. The Connecticut Medical Society honored him by selecting him to deliver the annual address in 1848. The New York State Medical Society elected him its president in 1860.

From Philadelphia the American Medical Association moved to Baltimore for its next convention which opened May 2, 1848. This year delegates came from 24 States, the District of Columbia, the Army and the Navy. Connecticut was represented by 28 physicians.\* The status of medical practice in that day may be surmised to some degree by a perusal of the opening remarks of the president, Nathaniel Chapman of Pennsylvania. "This assemblage," Dr. Chapman said, "presents a spectacle of moral grandeur delightful to contemplate . . . The profession to which we belong once venerated on account of its antiquity, . . . has become corrupt, and degenerate, to the forfeiture of its social position, and with it, of the homage it formerly received spontaneously and universally.

"The pilgrimage you have performed in coming hither at so many sacrifices of comfort and convenience, evinces the ardour of your zeal, and the loyalty of your devotion to this noble cause."

This zeal and devotion was recognized and repaid in a practical manner by a free passage home to all delegates on all the railroads of that day except the New York and Hudson River.

Connecticut continued to figure prominently at Baltimore as at New York and Philadelphia. N. B. Ives served on the nominating committee the first

\*From Connecticut Medical Society, Norman Brigham of Mansfield; from Hartford County Medical Society, Archibald Welch, Samuel B. Beresford, H. A. Grant, E. Carrington, David A. Tyler, Lyman Parker, A. Beardsley, N. C. Baldwin, D. L. Daggett, Joel Canfield, G. L. Platt, J. Goodsell, and N. B. Ives; from New Haven City Medical Association, Pliny A. Jewitt, Ebenezer H. Bishop, and S. Punderson; from Windham County Medical Society, J. Hammond; from Litchfield County Medical Society, Remus M. Fowler, George Seymour, A. A. Wright, R. M. Woodruff, and M. Peters; from New London County Medical Society, B. Fordyce Barker, and W. W. Miner; from Middlesex County Medical Society, Richard Warner; and from the Medical Institute of Yale College, Jonathan Knight and Henry Munson. Absent: Drs. Grant, Carrington, Tyler, Parker, Beardsley, Baldwin, Daggett, Goodsell, Bishop, Seymour, Woodruff, Miner and Munson.



day; but as all officers elected that day resigned a second nominating committee was selected by the delegates from the several states on the following day, and on this was placed Samuel B. Beresford of Hartford. Pliny A. Jewett of New Haven served as a teller at the first election of officers. Archibald Welch of Wethersfield was selected by the Convention to serve on a committee of five to prepare rules of order for the government of the Association. Jonathan Knight, vice-president, occupied the chair the afternoon session of the first day and again on the second day. Various standing committees were selected by the nominating committee, Dr. Jewett replacing Dr. Beresford in making these selections. Jonathan Knight was appointed to the Committee on Surgery and B. Fordyce Barker to the Committee on Publication. Samuel B. Beresford long will be remembered as the distributor of cigars to all who attended the meetings of the Hartford Medical Society, while he himself never indulged. He had an interesting career. Born in Dutch Guiana of English parentage, educated in the Barbadoes and later in England and Scotland, he practised medicine for seven short years in his native land. Then, with his physician-father who had been a medical officer in the British service, he came to the United States and settled in Hartford. He was a deliberate operator, especially skillful in obstetrics and ophthalmological surgery. Dr. Beresford was one of those tireless workers who took no vacation for pleasure over a period of twenty-five years. At the end of his term as president of the Connecticut Medical Society in 1868 he addressed his fellow members on "The Use and Abuse of Tobacco."

Pliny A. Jewett distinguished himself by his quick and able intellect, his cordiality toward his friends and his contempt for his enemies. He is described as noble in stature, dignified and courteous in manner, social to the extreme. Yale honored him by electing him to the professorship of obstetrics in 1856. The Connecticut Medical Society recognized his qualities of leadership by electing him its president for the year 1876 and by frequently selecting him to represent it at meetings of other State societies. We learn that "one of its (American Medical Association) earlier meetings at New Haven 'has kept his memory green' amongst the gray, as was attested at some of its recent sessions by kind inquiries, and a recounting of the courtesies and attentions then received at his hand, with mention of his wit and adroitness in reconciling clashing forces, and establishing at once apparently harmonious relations."

Dr. Jewett perhaps is best remembered as the organizer and commanding officer of Knight's U. S. Army General Hospital in New Haven during the Civil War.

Archibald Welch, then living in Wethersfield, had a deep interest in the State Society. His residence in that community of historical fame was not long, since, a few months after returning from the session in Baltimore, he moved to Hartford because "he could no longer endure the hardships of the practice of medicine in the country." This was at the age of fifty-four. Shortly before his death six years later he still was erect and vigorous, with an elastic step. His last days were spent in the service of organized medicine, attending the American Medical Association convention in New York City in 1853. With Samuel Beach of Bridgeport he met his death by drowning when his train went through the draw-bridge into the Norwalk River.

Joel Canfield was practising in Guilford at the time of the Baltimore Convention in 1848. The record shows that he was active later in the anti-slavery movement and a strong proponent of temperance. Gideon Platt went to Baltimore from Waterbury where he was engaged in surgery, obstetrics and the general practice of medicine. Remus Fowler was one of the representatives of the Litchfield County Society, practising in Washington. He too was a zealous advocate of temperance and a profound hater of slavery, and enjoyed an extensive consultation practice throughout his county and the neighboring towns in Massachusetts.

Of the absentees at Baltimore, David A. Tyler of New Haven was one of the best known. All his life he was obliged to combat the handicap of a delicate constitution. Suffering from repeated pulmonary hemorrhages, he was finally forced to give up his practice and busy himself with the study of botany in which he became an expert. The prolongation of his life to the age of sixty-seven undoubtedly may be attributed to this fortuitous change of occupation. In spite of his physical handicap, Dr. Tyler was a happy, cheerful soul, one of the most able, upright and honorable in the medical profession.

The assessment payable to the American Medical Association in those early days was \$3. We find George Sumner in 1847 credited with a payment of \$5. Certain physicians were designated as permanent members. In 1848 the list from Connecticut includes the delegates and members attending the Baltimore convention, and, in addition, Johnson C. Hatch,

Elijah Middlebrook, Ebenezer H. Bishop, Eli Ives, and George Sumner. Resolutions were passed at this session to the end that laws against the importation and sale of adulterated, deteriorated and misnamed drugs be passed. This was many years before the establishment of the Council on Pharmacy and Chemistry or the passage of the Pure Food and Drug laws.

Boston was selected as the place of meeting for the next session in 1849. At the Boston session one of the outstanding individuals was Worthington Hooker, a direct descendant of Connecticut's Reverend Thomas Hooker and a delegate from the New London County Society. His Report of the Committee on Medical Education appointed by the American Medical Association was reprinted in the Proceedings of the Connecticut Medical Society, 1852. In this report attention is called to the fact that the general standard of education and attainment is much lower in medicine than in other professions. This is attributed to a deficient preliminary education; a method of studying medicine by reading and attending lectures for a few months only; absenteeism from lectures, hospital, and dissecting room; and abuse of the method of examination for degrees. The profession was labelled overcrowded and comprised mostly of unworthy and ignorant men. Dr. Hooker as a member of that committee in 1849 and its chairman the following year, undoubtedly knew whereof he spoke. Well trained, a graduate of Yale College and Harvard Medical School, for several years a practising physician in Norwich, he later succeeded Dr. Ives at the Medical Institute of Yale as professor of Theory and Practice of Medicine. He was the author of many essays and published several books.

Dr. Hooker offered the resolutions at the annual meeting of the Connecticut Medical Society held in Gilman's Saloon, Hartford, May 11, 1853, five days after the railroad accident in Norwalk. The last paragraph of these resolutions strikes a familiar note: "Resolved, that the very prominent carelessness, both in the selection of individuals for important and responsible posts, and in the adoption of ob-

vious and necessary precautions against accidents, deserves the most emphatic rebuke from the community, and urgently calls for the immediate enactment of stringent laws on this subject on the part of our legislatures."

In 1860 the American Medical Association honored New Haven with its annual session. The president that year, Dr. Henry Miller, introduced the subject of illegal abortion and urged action against this practice by the legislature in every State. The clouds of war soon gathered over the nation. The leaders of organized medicine became the leaders in the armies and navies on both sides of the Mason-Dixon line. For two years an annual gathering of physicians from the various States was impracticable, even impossible. The parent organization did not assemble its delegates again until 1863 when for the first time Chicago acted as host. Connecticut was never again to have the honor of being host to the annual gathering of the parent organization. In spite of that fact the significant early years of the American Medical Association bear stirring testimony to the wisdom and leadership of many of Connecticut's great physicians.

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## EDITORIALS

### A New Challenge

The education of the public in the subject of cancer is no longer an immediate problem. Cancer is one of the most popular subjects today and the success of the fund raising campaign is a potent witness to the great public interest in the subject. At present the problem seems to be one of educating the physician, not only the family doctor but every physician who comes in contact with patients. This education embraces diagnostic and therapeutic knowledge, and also an awareness of the great public demand for service in these procedures.

This year the American Cancer Society and the U. S. Public Health Service will spend sixteen million dollars. Added to this will be another six to eight million spent by state health departments. Beside Senator Pepper's bill appropriating 100 million dollars for cancer research there are at least four other bills in Congress on cancer.

None of the objectives planned by these extensive measures can be effective without cooperation and intelligence on the part of the medical profession. The important question that comes at this time is how the diagnostic and therapeutic aspects of the problem are to be handled in the immediate future. It is obvious that one method rests in the further development of the cancer detection center where, if properly organized under the aegis of teamwork, both quantity and quality service can be given. Thus far for the most part these clinics have been directed to caring for the medically indigent or near indigent.

If the more favored economic groups are to receive this service from private physicians it seems reasonable to assume that it will have to be equally well done. Whether this is a suitable answer for this group of patients remains to be seen. Medicine is becoming more and more aware of the great advantages to be obtained from group endeavor, both from the patient's and the physician's viewpoint. The success of the already established cancer detection centers throughout this country proves the public's desire. In any event, a great popular demand in the field of cancer is beginning to be widely felt and intelligent planning must go forward without delay.

### Afterthought

The recent State meeting was the largest ever held by this Society, with an attendance well over eight hundred. Its unusual success was due to many factors, which include the fine management on the part of those who planned and carried out the excellent program, and the very adaptable physical facilities offered by the Hamden High School. The commercial exhibit, always an interesting part of these meetings, left little to be desired on the part of the exhibitors and those who were interested in viewing the displays. Only those who have had intimate knowledge of the machinery of such an undertaking can appreciate the meticulous attention that must be exercised to keep it running smoothly. In this the personnel of our Executive Office played a major role and it is, therefore, to Dr. Barker and his asso-

ciates that great credit must be given. In after consideration certain thoughts come to mind concerning future annual meetings of this Society.

We have every reason to expect that attendance of such meetings will not be less but will be even greater. What facilities can be found in our State to handle such numbers becomes therefore a major concern for future planning. At present no existing hotel accommodations appear to be adequate for general meetings, section meetings, commercial exhibits, and luncheon arrangements, which are the four basic needs. It may be that school facilities, similar to those existing at Hamden, will be the only recourse. Geographical location is also an important consideration. The Hamden High School was ideal in that it is located within a dozen miles of the center of physician population of our State. In any event, future planning has many things for its consideration: bigger and better meetings obviously should be our desire but sharp thinking will have to accompany that aim.

### Connecticut and the Founding of the A.M.A.

Dr. Weld, in his stimulating essay on this subject, has made an important addition to the annals of Connecticut medicine. The part that our Society played in the establishment of the national organization, which this year celebrates its centenary, was no small one. In fitting recognition of this, in the planning of the celebration the chairman of our Council, Dr. Murdock, was chosen to have a responsible share. As we learn more about these distinguished medical ancestors who represented our State in the early years of the American Medical Association, we are impressed not only with their professional attainments but with the numerous instances in which these doctors assumed burdens of other public responsibilities. Would that today in our legislative halls the voice of medicine was more often heard directly and not as one crying in the wilderness. We have recently been reminded by both Dr. Sensenich and Dr. Fishbein of the important influence that our Connecticut representatives are exerting in the national affairs of medicine. We enjoy such pleasant words but they come as no surprise, for we are aware of their capabilities. They are following notable examples now again brought to our attention by Dr. Weld's timely contribution.

### The Hartford Hospital Bulletin

We salute the first number of this new publication and congratulate Dr. Phelps and his co-editors on the appearance and content of an interesting addition to Connecticut medical literature. The Bulletin will serve to reinforce the extensive teaching program which has been developed at the Hartford Hospital for the resident staff and physicians of the community. Besides numerous case reports excellently illustrated is included a schedule of conferences which gives a good idea of some of the activities which are incorporated in the program. Also, in this issue is the announcement of the recent accreditation by the National League of Nursing Education of the Hartford Hospital School of Nursing, now one of 120 schools so accredited in this country.

The Hartford Hospital Bulletin is fresh evidence of the effort that is going on in medical centers to increase the efficiency and quality of medical care and to assume the responsibility for medical service that now faces American Medicine.

### The Meriden Hospital Bulletin

There is always something exciting to an editor when he sees the words Volume one, Number one. The Meriden Hospital Bulletin comes across the desk in its initial issue of April 1947 in finished and attractive form. As a record of the activities of the Hospital Staff, its purpose is stated as "a medium wherein the members of the staff may note their experiences in the practice of medicine and serve as a stimulus to these men and women to continue their studies to improve our profession and to share their knowledge with our confreres."

In this issue are articles on Polycystic Kidneys by E. W. Czerny and R. Katzenstein, The Management of Thrombophlebitis by A. J. Ryan, Vegetative Endocarditis Complicating Diabetes Mellitus by B. L. Mills and E. W. Czerny, Some Problems of Alcoholism in a General Hospital by C. I. Solomon, and an impressive list of Staff Meetings and Staff Conferences with local and guest speakers.

We predict a successful future for this fine example of the spirit of enterprise in one of our smaller general hospitals. This conviction is strengthened by the common knowledge of the excellent and progressive work that has been done and is being done at the Meriden Hospital. Bon Voyage!



### Rural Medical Service

Dr. Gardner in his paper on State planning for rural medical service emphasizes many points which are important in future developments in medicine. Not the least of these is that the rural groups of our citizens both state and country-wise have great influence in legislative affairs. That they shall receive good medical care is definitely the concern of medicine. One effort along this line which is going forward and which will be watched with interest is the development of group practice centers. In one small New England town this has centered around a thirty-bed hospital which serves a sizable area. As a result this community is provided with knowledge and equipment not possible under other former circumstances.

A further problem which will face us shortly in Connecticut is the working out of some plan whereby our rural citizens can obtain the benefits to be offered by medical care insurance.

### The Eye Bank for Sight Restoration, Inc.

The donation of one's eyes to the great humanitarian purpose of saving or returning sight to the living has been placed on a nation wide and business like basis since February 1945, when the Eye Bank for Sight Restoration was incorporated in New York.

Many details are connected with the collecting and distribution of corneal tissue and vitreous and the accomplishment of this high purpose. The majority of the details are centered in the Eye Bank for Sight Restoration, Inc., in New York City, but others must be taken care of locally when the eyes are donated.

The Eye Bank, whose contribution to human welfare and the specialty of ophthalmology cannot be easily described or measured, needs more support in the coming year. As the center for collecting and distributing fresh corneal tissue and vitreous, no organization like it exists on earth.

The Eye Bank is fostering a sound research program. Young ophthalmologists, both American and European, there find the tools to begin their study of corneal transplantation. There they keep in touch with the latest technical advances, well tried before publication.

Nationwide interest of the laity in the Eye Bank's

program for collecting and distributing eyes offers each hospital in the country a chance to become an important cog in the wheel of sight saving. Eyes do not just fly to New York for distribution. They must be removed immediately after death, by someone on the scene, under surgical conditions, transported to the airport, and only after arrival in New York may they be distributed by the Eye Bank.

People who wish to donate their eyes should find it easy to do so. The greatest service we can offer these people and the Eye Bank is the setting up of an administrative routine in our cities to handle the removal of and the transplantation of the eyes at all hours of the day and night. We may use our hospital residents and preceptors in ophthalmology, or trained technicians. The great problem is not getting people to donate their eyes, but setting up the machinery for collecting eyes from individuals. Each hospital that considers itself a public servant could well consider offering their services. While there is less need for such services than for blood banks it offers an unprecedented opportunity to help both blinded patients and prospective donors of eyes.

Corneal preservation may become possible, but at this time only fresh tissue is usable, so that the supply of eyes to those that may need them rests entirely on the collections that are made throughout the country from day to day.

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### Student Nurse Recruitment Program

Dr. Fritjof H. Arestad, associate secretary, Council on Medical Education and Hospitals, had been designated A.M.A.'s representative to advise with the American Hospital Association on the student nurse recruitment campaign. The Board of Trustees of the American Hospital Association has appropriated \$10,000 from the Association's funds to initiate a national student nurse recruitment program. A yearly expenditure of \$50,000 is anticipated. The American Nurses' Association, the National League of Nursing Education, the National Organization for Public Health Nursing and the A.M.A. have been asked to participate.

The Advertising Council, Inc., of New York City has accepted nurse recruitment as one of its public service projects. This will insure on a widespread basis radio time, display advertising and assistance in writing copy for local and national advertising.

## THE PRESIDENT'S PAGE

### KNOW YOUR OWN SOCIETY

IT is a surprising truth that many of our newly elected members know more about the activities of our state and county organizations than some who have been members for many years.

The younger members in our Society have become intimately acquainted with the state office either because of its interest in their war service, or because they have made their first Connecticut contact with the Medical Examining Board in our office.

When physicians accept responsibility in the medical organization they should take the time to acquaint themselves with the details of the organization, not only by study, but by discussion with those experienced in Society affairs. Misunderstanding will be avoided if they realize that some projects may already have been considered and discarded. Youth is sometimes impatient with experience, but it loses something if it disregards mature counsel.

A medical society, to be useful, must help in the solution of problems that confront the profession. The young members should be encouraged to accept responsibility early, and to become familiar with the Society's operations.

The Board of Trustees of the American Medical Association has prepared a handbook and directory to be placed in the hands of each newly enrolled Fellow so that at the start of his professional career he may be better acquainted with the organization which is so vital to his welfare. By the way, do you know the difference between membership and fellowship in the A.M.A.? I suggest that you ask someone who knows.

James Raglan Miller, M.D.



## REPORT OF THE PRESIDENT TO THE ANNUAL MEETING OF THE HOUSE OF DELEGATES APRIL 28, 1947

THE AGENDA for the 155th Annual Meeting of the House of Delegates of the Connecticut State Medical Society presents a comprehensive digest of the activities of the Society during the past years. The reports to be submitted indicate the healthy condition of the Society, pertaining as they do to so many subjects that are vital in the field of medicine. These reports reflect the work of committees and officers, representing a broad cross section of our membership, who have been diligent in their search for means to improve medicine and our Society.

It is good to see a larger number of physicians taking a more active interest in the affairs of the organization; and the Society may well rejoice that alert and forward looking men are giving their time and energy to its needs. Our veterans who have had opportunity to envision medicine from a new perspective, and our younger members who have come to us with refreshingly open minds, are making contributions of strength and enthusiasm. Our elders, with deep appreciation of our heritage, weld into our activities the wisdom of experience.

Membership in the Society is at its highest level in history. Our County Associations evince desire to provide programs that serve to promote the scientific and social intercourse of their members. The individual physician is exhibiting more interest in his County Association; he is becoming increasingly aware of its importance as a medium for integrating physicians into movements designed to improve the quality of medical care. Too, there has developed in certain counties an attitude of healthy inquiry directed toward the functions of the County Associations as related to the State Society.

This report will not attempt to point up accomplishments that will be detailed in other fashion. Rather its intent will be to acquaint the House of Delegates with certain matters pertaining to the make-up and workings of the Society.

By way of background, it should be stated that your reporter has sat with the Council of the Society for two years. He has been privileged to work with the eight County councilors, the president-elect, the executive secretary, the treasurer, the three delegates to the American Medical Association, and the Editor of the JOURNAL. He has seen the careful

attention that is given by this body to the many subjects presented that are of importance to medicine in Connecticut. He has seen divisions of opinion as to methods of procedure. He has never seen division of opinion affecting the best interests of the Society.

He has been privileged to visit the eight County Associations on more than one occasion. Here he has met, rubbed elbows, and exchanged thoughts with the members who make up the splendid body of our organization. He has travelled afield and learned at first hand in what high repute Connecticut medicine is held in the country. He has seen plentiful evidence of the thought and strength that our delegates provide for the legislative affairs of the American Medical Association. He has witnessed the able contributions that have been made by Connecticut's representative on the Board of Trustees of the American Medical Association.

In all, for two years he has been close to able men, earnest in their desire to improve the quality of medicine, and diligent in their efforts to promote closer cooperation between physicians. From this perspective it was but natural that thought be given to methods for enhancing the value of the Society to its members.

This thinking further crystallized when our able and perceptive Executive Secretary, at the semi-annual meeting of the House of Delegates in December, introduced a resolution for the appointment of a Committee to Study the Organization and Objectives of the Society. The resolution was approved unanimously, the Committee has been appointed, and already it has begun to function.

In order that the House of Delegates may be fully aware of the field of activity of this Committee, I shall discuss the material which was presented to it for study. The Committee is not expected to limit the scope of its survey. An evaluation of all of the activities of the Society is desirable. Likewise, the machinery of the Society requires analysis, as to its present efficiency, its adequacy, and its need for modifications to meet present day and future problems.

One important component of the Society, the Council, is recommended for close scrutiny. The

functioning of the Council has been that of an executive committee for the House of Delegates, a nominating committee for the officers and committees; a finance committee for the Society; a liaison committee with public and private agencies; and a referral committee in matters of policy of the Society. The opinion has been expressed that since only eight members of the Council are elected by counties, and the remainder consisting of president, president-elect, executive secretary, treasurer, editor of the JOURNAL, and three delegates to the American Medical Association are nominated by the Council, a condition exists whereby the counties may fail to receive recognition and adequate representation in the business of the Society, and also under these circumstances perpetuation in certain offices may be possible.

It was suggested to the Committee, therefore, that the composition of the Council be studied along these lines: Should the Council be enlarged to give the counties greater representation. If so, how should additional councilors be elected.

Would closer relationship between county and state organizations be accomplished if county secretaries were made additional councilors. Should tenure of office of councilor be limited, either by restricting the number of terms for which he may be reelected, or by increasing length of term and prohibiting a councilor to succeed himself?

Should there be additions to or deletions from the list of those officers now designated as members of the Council? Should all members of the Council be entitled to vote on Council deliberations? Should policy be established in relation to dual office holding?

It was also suggested that the Committee consider whether or not the Council should continue to nominate all officers and committees; or should a Nominating Committee be appointed by the House of Delegates; or should nominations for certain officers and committees be made by County Associations; or does the entire procedure of nominations require overhauling?

The Committee was requested to study the financial operations of the Society and the functions of the Treasurer. The expanding activities of the Society and the development of greater usefulness to its members depends upon the financial resources of the organization. If additional income appears to be needed, it should be determined what expansion of the value of the Society may be expected, and

how such additional income should be obtained.

Inquiry was suggested to determine the federal tax position of the Society from the standpoint of the Federal Income Tax, Business Tax, and Social Security contributions. The Committee was also asked to consider the establishment of a policy relating to the expenses of officials, committees, and employees of the Society.

The operations and responsibilities of committees were presented for study. It is probably true that wider individual interest in the Society can be accomplished by appointing a greater number of our members to committees. On the other hand, some of our committees have failed to function, either because the subject was of small import or because of the disinterest of appointees in a particular subject.

The entire matter of committees needs study to determine if we have too few or too many; whether the make-up should be larger or smaller; whether wider or more restricted local representation would be helpful; and what new fields require committee exploration or other activity.

The relationship of the Society to the public, and its concern with organized groups, other societies, and various institutions have been developed from lessons learned in the practice of our profession or have come about by natural evolution, expedient promotion, or pure chance.

It is probably true that for a time the equivocal position of the medical profession may have been due in some part to a lack of organized medical society effort in the field of public relations, and in part to the failure of the Society to integrate itself properly with the modern concepts of community life. We now recognize the importance of understanding the objectives of others, and we realize to what extent medicine may profit by cooperation in other fields of endeavor. There is need for clarification of the educational purposes of the Society. Evaluation of the methods now in vogue is required, and plans should be formulated for expansion of its educational activities.

The bond between the State Society and the County Associations is essential. Every opportunity should be seized to vitalize this relationship. It can be strengthened in no better fashion than by mutually designed and mutually activated educational programs for our members and for the public. For instance, there should be a clearly defined basis of relationship between the Society and certain public



agencies such as the State Department of Health; county and municipal health departments and welfare departments; Veterans' Administration; commissions with various health related objectives; state hospitals and sanatoria and other institutions; state and municipal departments of education; medical personnel in public institutions and departments; agencies dealing with the medically indigent, etc.

Similarly, thought should be given to the development of cooperation between the Society and private agencies such as the dental, nurses, and pharmaceutical associations; educational institutions, particularly Yale University and the University of Connecticut; public health and visiting nurse associations; labor unions; occupational groups such as the Grange or the Farm Bureau; civic organizations; Chambers of Commerce; Manufacturers' Associations; Veterans' organizations; Women's Clubs, Parent-Teacher Associations, etc.

The attitude of the Society toward legislative matters requires study. It can be questioned if we give sufficient attention to legislation affecting physicians, the health of the public and the distribution of medical care. At times it has been difficult to arouse our members to interest in proposals, that if enacted, would have had far reaching effect upon the entire practice of medicine. Too many physicians

give little thought to the use of their knowledge and influence in molding opinion concerning laws that affect the health of the people. There is need for stimulation and education of our members to accept responsibility in these matters.

From what has been said it should not be concluded that our Society is in a sad state. Indeed, the contrary is true, but we must constantly remember that we live in a moving world. Our heritage is rich, our accomplishments have been good; but we must continue to build and progress from those foundations. The Society could benefit from the constant scrutiny of a committee such as the one now undertaking the project outlined above.

I extend my grateful thanks to the officers and committees for their cooperation and understanding. I can not too highly commend those in our central office: Dr. Barker, Dr. Mooney, Mr. Burch, and the office staff for their efficiency and their devotion to the welfare of the Society. To have labored and communed with all of these has been a rich and happy experience.

The House of Delegates and the members of the Society have bestowed upon me an honor of which I am humbly proud and for which I shall always be deeply grateful.

Cole B. Gibson

## RESOLUTIONS PASSED BY HOUSE OF DELEGATES — APRIL 28, 1947

### RESOLUTION ON HOUSE BILL 953

Mr. President:

At the meeting of the House of Delegates during the 140th Annual Meeting of The Connecticut State Medical Society, held at New Haven May 26, 1932, the following resolution was unanimously adopted:

*"Whereas, the health- and life-preservation of women renders necessary advice concerning the prevention of conception and the prescribing of various prophylactic measures for that prevention; and*

*Whereas, prevention is medically superior to surgical interference as a therapeutic measure; and*

*Whereas, such health- and life-preservation procedure is the responsibility of the trained Medical Profession rather than of any other group or agency; and*

*Whereas, existing statute in the State of Connecticut interferes with the medical duty and with the intelligent use of scientific knowledge for health- and life-preservation of a vitally important group of the citizenry; and*

*Whereas, legal authority should be secured for physicians to exercise their proper duty to protect and to procure for their patients the best possible state of health, including—when required—the prevention of conception; therefore be it*

*Resolved: that The Connecticut State Medical Society shall present to the 1933 General Assembly of Connecticut for enactment the following amendment to Section 6246 of the General Statutes: add to Section 6246 the following sentence: "provided however that nothing in this section shall apply to a physician licensed to practice under Chapter 153 of*

the General Statutes nor to any patient acting under the supervision or advice of such physician, when in the opinion of such physician pregnancy would be detrimental to the health of the patient or to the child of such patients"; and further be it

*Resolved:* that any physician who shall assist in the prevention of conception for any other purpose than the protection of the health of the mother and child shall be deemed guilty of unprofessional conduct, and, upon conviction, shall be disciplined accordingly."

Inasmuch as at the present time there is before the General Assembly a Bill, known as the Alsop bill (House Bill 953), which fulfills the objectives of the foregoing resolution, the enactment of which would permit any licensed physician to prescribe for his married women patients methods or means for the prevention of pregnancy when in his opinion such pregnancy would endanger the life or injure the health of such married women; be it

*Resolved:* that this House of Delegates endorse House Bill 953 and urge its prompt enactment.

#### RESOLUTION ON REQUIREMENTS FOR STAFF MEMBERSHIPS IN HOSPITALS

*Whereas,* The problem of hospitalization is urgent now and will be distressingly difficult for an indefinite period of time; and

*Whereas,* There is apparently a definite plan to limit staff membership in hospitals to diplomates of the various Specialty Boards; and

*Whereas,* The limiting of staff memberships and Heads of Departments of such Staffs in hospitals to such diplomates could tend to injure the best interests of the public and the medical profession as a whole; and

*Whereas,* Of a total of 180,000 physicians in the United States, approximately only 22,000 are diplomates of all Specialty Boards, and limitation by the hospitals of their facilities to use by these few would work an injustice on other capable doctors and their patients; therefore, be it

*Resolved,* That the House of Delegates of the Connecticut Medical Society go on record as favoring the following suggestions in regard to Staff membership in hospitals:

1. Adequate protection of the rights of all doctors and their patients in obtaining hospitalization to the end that general practitioners, as well as specialists, shall have access to, and use of, hospital facilities.

2. That the criterion of whether a doctor may be

a member of a Staff or Head of a Department shall be his actual ability as a doctor, and not dependent on special Society or Board membership.

#### RESOLUTION ON DEBARRING OF PHYSICIANS FROM HOSPITALS

*Whereas* it has recently come to the attention of the members of this society that six reputable physicians, all members of the Connecticut State Medical Society, have been advised by three general hospitals of this state that they may no longer practice in these hospitals for reasons that have nothing to do with the proper practice of medicine;

And *Whereas* they have not infringed on the codes of these hospitals while pursuing their professions within their walls;

And *Whereas* these hospitals accept public funds raised by general taxes from all the people of this state regardless of their religious beliefs;

And *Whereas* the action of these hospitals in denying their facilities to these doctors sets a dangerous precedent which may well result in the debarring of all physicians who do not conform in their entirety to the religious beliefs of those governing these hospitals;

Therefore *Be It Resolved* that the Connecticut State Medical Society at its annual meeting held April 28, 1947, voices its disapproval of the action taken by these hospitals and that a copy of this resolution be sent to all general hospitals in the State of Connecticut.

### Undulent Fever

From two states in different sections of this country come reports of the increase of undulent fever. Dr. Thurman B. Rice of the Indiana State Board of Health reminds us that undulent fever is one of our top flight enemies. In Indiana brucellosis is not a rare disease but too often it is not recognized until it has become chronic, when the management problems are materially increased.

In a recent issue of the *Journal of the Medical Association of Georgia* are published three case reports of undulent fever. In that State brucellosis is said to be definitely an increasing menace to health and unless proper preventive measures are taken it is anticipated that it will become progressively worse. It must be remembered that this is an evasive disease and requires persistent efforts to establish a diagnosis.



## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN



Dr. Roscoe L. Sensenich, chairman of the Board of Trustees, American Medical Association, is shown in the above picture, center, conversing with Dr. Cole B. Gibson, left, retiring president and newly elected treasurer of the State Medical Society, and Dr. James R. Miller, right, president of the Society, during the annual dinner held at the New Haven Lawn Club, Tuesday evening, April 29

A record attendance of approximately 1,000 physicians was established during the 155th annual meeting of the Society held at the Hamden High School on April 29 and 30.

The total number of registrants reached 843, but it is estimated that at least 150 individuals did not

register. Approximately 300 registrations were recorded during the first few hours of the meeting on Tuesday morning, an unusually large number when compared to former meetings.

During the many active sessions of the meeting, the facilities of Hamden's modern high school



proved most adequate. This greatly aided the planning and management of the meeting, and it would be difficult to find more suitable accommodations to meet the needs of such a large gathering.

Apparently impressed with the facilities, several persons suggested that the school be selected for all future annual meetings. In view of the record attendance and the reasonable expectation that it may increase in the future, it might be wise to seriously consider these proposals.

A few years back, when annual meetings of the Society were attended by not more than 200 physicians, it was a comparatively simple matter to secure an adequate meeting place in any of our larger cities. Now we no longer need be unduly concerned about getting people to attend the meetings, but must feel increasing concern about how to take care of them when they do attend.

Although the date of the meeting was changed this year to coincide with the school's spring vacation, and this brought the event quite close upon the county meetings, no considerable difficulties were apparent in this connection, except some confusion in determining membership in the House of Delegates.

The facilities provided by the school cannot be mentioned without remarking upon the most generous cooperation of the Hamden Board of Education and school officials. At no time has the Society been accorded more friendly and interested support. The efforts of the custodial staff and the students selected to operate the check room, refreshment booth, and other services were of appreciable value in achieving efficient operation.

The success of the two days of clinical addresses and symposia was augmented by the success of all other functions held in connection with the event. The annual meeting of the House of Delegates transacted an unusually large amount of business under the able chairmanship of Cole B. Gibson, retiring president. The annual dinner of the Society, held at the New Haven Lawn Club, attracted an attendance of 318 persons, filling the spacious dining room to capacity. Newly elected and retiring officers of the Society and members of the program committee for the annual meeting were entertained at a dinner given by the Council at the Lawn Club on Monday evening, following the meeting of the House of Delegates.

One of the outstanding features was the excellent attendance at the section meetings, and the facilities

for these were generally satisfactory. The section meetings are attracting increasingly large numbers each year, and the provision of space for them brings an added complication into annual meeting plans.

Thus, as the 155th annual meeting becomes history it will be recorded as the largest meeting of all time, and perhaps the most enthusiastically received.

### New Appointments by Governor

Dr. W. Bradford Walker, of Cornwall, recently received appointment to the Connecticut Public Health Council by Governor James L. McConaughy. The appointment is effective July 1 for a term of six years.

Formerly president of the Connecticut Public Health Association, and past president of the Litchfield County Medical Association, Dr. Walker will succeed in his new appointment David R. Lyman, who is retiring from the council following eighteen years of continuous membership. Medical superintendent of Gaylord Farm Sanatorium, in Wallingford since 1903, Dr. Lyman is a past president of the



W. BRADFORD WALKER, M.D.





HENRY A. ARCHAMBAULT, M.D.



HOWARD S. COLWELL, M.D.

Connecticut State Medical Society, the New Haven County Medical Association, the American Sanatorium Association, and the National Tuberculosis Association.

Dr. Henry A. Archambault, of Taftville, and Dr. Howard S. Colwell, of New Haven, were recently appointed by Governor James L. McConaughy to

serve on the Board of Directors of the Connecticut State Farm for Women and State Prison for Women, in Niantic. Dr. Colwell's appointment fills a vacancy left by the resignation of Robert B. Whiting, of Norfolk. The term expires July 1, 1951. Dr. Archambault's appointment is effective July 1 for a term of five years.

## New Members Elected at Annual Meetings

### FAIRFIELD COUNTY

Michael C. Anton, Stratford  
 Richard R. Barber, Stamford  
 G. Burnham Beaman, Stamford  
 Rudolf Braun, Bridgeport  
 Forbes H. Burgess, Ridgefield  
 Silvio J. Caserta, Bridgeport  
 Tzu Pei Chou, Stamford  
 William H. Curley, Jr., Bridgeport  
 M. David Deren, Bridgeport  
 Lindo P. DiFrancesco, Stamford  
 John J. Dobkins, Stamford

John Donadeo, Bridgeport  
 Dean H. Edson, Danbury  
 Benjamin Epstein, Danbury  
 Howard A. Felding, Stamford  
 Homer W. Grimm, Fairfield  
 James L. Hanley, Jr., Bridgeport  
 Robert J. Hansell, Greenwich  
 George B. Kyle, Sandy Hook  
 Ellen F. Leong, Stamford  
 Vincent A. Lynch, Bridgeport  
 Charles T. Meacham, Stamford  
 George J. Molnar, Bridgeport  
 Frank F. Northman, Bridgeport  
 Faith N. Ogden, Norwalk

Andrew P. Owens, Bridgeport  
 Michael R. Scully, Bridgeport  
 Benjamin Sherman, Bridgeport  
 Alfred G. Siege, Bridgeport  
 John G. Snavely, Stamford  
 Duncan C. Stephens, Newtown  
 Samuel Turetsky, Bridgeport  
 Leonard C. Veneruso, Bridgeport  
 Eugene A. Wrona, Stamford  
 Isidore Yasser, Bridgeport  
 Michael M. Yoburn, Danbury  
 John B. Zielinski, Bridgeport

## HARTFORD COUNTY

Charles M. Barbour, Jr., Hartford  
 Francis D. T. Bowen, Hartford  
 Philip S. Breznia, Bristol  
 Robert H. Campbell, West Hartford  
 James A. Dolce, Hartford  
 Theodore M. Ebers, Hartford  
 Charles P. Elsberg, New Britain  
 Hollis J. Foster, Jr., Berlin  
 Max R. Goldstein, Hartford  
 Jack Gurwitz, Newington  
 Charles H. Hamlin, East Hartford  
 William E. Kenney, Hartford  
 Seymour M. Miller, West Hartford  
 James J. Moher, Hartford  
 Harold F. Pierce West Hartford  
 Aaron Plachta, Hartford  
 Theodore Rosen, Manchester  
 Siegfried S. Schatten, West Hartford  
 Theodore P. Sohler, Wallingford  
 Oscar H. Zarkin, Hartford

## LITCHFIELD COUNTY

Graham B. Blaine, Jr., South Kent  
 David A. Grendon, Kent  
 Joseph C. Reidy, Winsted

## MIDDLESEX COUNTY

Americo D. Longo, Portland  
 Harold E. Smith, Middlefield

## NEW HAVEN COUNTY

Morris J. C. Allinson, New Haven  
 Maurice F. Beauchamp, New Haven  
 William C. Carbone, Hamden  
 Anthony P. Cipriano, New Haven  
 Marcus E. Cox, Waterbury  
 Lawrence S. Crispell, Bridgeport  
 Christopher E. Dwyer, Waterbury  
 Arnold Gesell, New Haven

Francis Giuffrida, Meriden  
 Michael Gompertz, New Haven  
 William Grillo, Waterbury  
 Millard C. Hanson, Waterbury  
 Mary L. James, Waterbury  
 John E. Keller, New Haven  
 Lawrence G. M. Lydon, New Haven  
 Robert F. Malone, Milford  
 James D. McGaughey, III, Wallingford  
 John J. Milici, New Haven  
 Thomas M. Mulligan, Waterbury  
 George H. O'Brasky, New Haven  
 John P. Riesman, Branford  
 Samuel A. Robb, Meriden  
 J. Harold Root, Jr., Waterbury  
 Harry Sigal, New Haven  
 George C. Sivak, Ansonia  
 Paul Teiger, Waterbury  
 Walter A. L. Thompson New Haven  
 Frank Tortora, New Haven  
 James G. Tynan, Waterbury  
 William R. Willard, New Haven  
 Charles C. Wilson, New Haven  
 Paul Winer, New Haven

## NEW LONDON COUNTY

Ilse V. Colett, Norwich  
 Bradford B. Crandall, Mystic  
 Henry L. Haines, New London  
 John W. Platt, Mystic  
 Harold D. Von Glahn, Old Lyme

## TOLLAND COUNTY

Siegfried D. Firestone, Rockville

## WINDHAM COUNTY

Conrad S. Baker, Willimantic  
 Robert Dinolt, Putnam  
 William S. Maurer, Willimantic  
 Marion L. Whalin, Storrs

### Centennial at Griswold Inn, Essex

The ancient Inn where the meeting took place was originally built by Sala Griswold in 1776 as a hostelry for coach and river travelers. It has since been enlarged to twenty-eight rooms, and is now owned and managed by Mr. and Mrs. Arthur Lovell. Mrs. Lovell is a direct descendant of Sala Griswold.

The rustic banquet hall, recently added to the rear of the Inn, was formerly a colonial powder mill in Gonic, New Hampshire. Constructed in 1750,



the mill ground out gun powder for New Hampshire's embattled farmers during the Revolutionary War. It was dismantled and brought to the Essex site under the supervision of Mr. Lovell.

During the colorful years when passenger steamers plied the Connecticut River between Hartford and New York, the Griswold Inn was nightly a scheduled stop for many travelers. Evidences of the steamboat era abound in the hotel. Framed lithographs of many river boats, including the famed Pilgrim and Priscilla, said to have been so luxuriously

appointed that each first-class stateroom was brightened by a canary singing in a golden cage, line the aged wooden walls of the dining room. Suspended from the roughly hewn beams in the banquet hall are several of the huge shining brass lanterns which were once the riding lights of the historic Pilgrim.

Preparations are now being made to accommodate the considerable number of visitors from all parts of the country who each summer descend upon the Inn as one of their scheduled points of contact with the colonial history of New England.



The centennial celebration of the Central Medical Society and the annual meeting of the Middlesex County Medical Association were held at the historic Griswold Inn, Essex, on April 9.

Physicians at the speakers table, shown in the above picture, included: front row, left to right: Thomas P. Murdock, chairman of the Council of the State Medical Society; Cole B. Gibson, retiring president of the State Medical Society; Morris Fishbein, editor of the *Journal of the American*

*Medical Association*; Jessie W. Fisher, consulting pathologist, Middlesex Hospital; James Murphy, historian, Central Medical Society.

Rear row, left to right: Stanley B. Weld, editor of the *CONNECTICUT STATE MEDICAL JOURNAL*; James R. Miller, president of the State Medical Society; Charles Russman, president, Central Medical Society; Creighton Barker, executive secretary, State Medical Society; and Harry S. Frank, chairman, centenary program committee.

### Major Crane Cited by the Army

Major James E. Crane of Stamford, holder of several citations for service during World War II, was awarded an Oak Leaf Cluster to the Bronze Star

Medal on April 18 by Capt. Henry L. Timmerman, U. S. Army recruiting officer for Fairfield County.

The citation accompanying the award states that Major Crane "performed meritorious service in



Java from January 17 to February 27, 1942."

"As Flight Surgeon with Headquarters, Far East Air Force," the citation states, "he served with distinction in the defense of Java and the Philippines, and in delaying the encroachment of the Japanese into New Guinea."

After nearly five years of service in the Army Medical Corps, Major Crane was honorably discharged and is associated with his father in the practice of medicine in Stamford while serving as assistant resident physician at Bellevue Hospital, New York.

A graduate of the University of Vermont, Major Crane served with the medical corps in Egypt, New Zealand, China, Burma, India, Java and Australia. He was a pioneer in establishing the air ambulance system in the South Pacific.

### Anesthesia Section Meeting

The Section of Anesthesia of the State Medical Society held its annual meeting in Hamden on Tuesday, April 29. A total of 53 members and visitors were present.

Two very interesting and instructive papers were presented concerning important practical aspects of anesthesiology. A symposium on complications of anesthesia, followed by an informal discussion concerning problems incident to the anesthesiologist, was also held.

During the course of the business meeting, the following officers for the coming year were elected: Stevens J. Martin, St. Francis Hospital, Hartford, president of the State Society of Anesthesia and chairman of the Section of Anesthesia; Arthur Adams, Charlotte Hungerford Hospital, Torrington, secretary-treasurer. The president then appointed Charles Barbour, Hartford Hospital, Hartford, as chairman of the Program Committee.

Plans are being made to expand the Society membership as well as to increase its activities during the coming year.

### Meeting of Section of Obstetrics and Gynecology

The Section of Obstetrics and Gynecology of the Connecticut State Medical Society met at 3:15 P. M., April 30, with Thomas J. Roche, Bridgeport, acting chairman.

Joseph H. Howard, Bridgeport, presented an interesting paper offering "Procedures for Reducing Maternal Mortality" based on an exhaustive review and analysis of the "Maternal Mortality Statistics of Connecticut" during 1940-45. James R. Miller dis-

cussed the subject and compared the statistics with those quoted in his paper covering the period 1909-28. He reported that there had been no maternal deaths in the last 608 deliveries at Hartford Hospital. Herbert Thoms suggested that a comparison of techniques used in various hospitals should be analyzed in an attempt to improve the record in those areas reporting an unduly high mortality rate.

At the business meeting of the Section the following officers were elected: Thomas H. Roche, Bridgeport, chairman; Orvan W. Hess, New Haven, vice-chairman; Harry F. Pennington, Meriden, secretary; member of Nominating Committee, Charles Peckham, Manchester; member of Executive Committee, Charles G. Barnum, Groton.

### New England Proctologic Society

The 20th semi-annual meeting of the New England Proctologic Society was held at the Faculty Club, New Haven, on May 9. The program was arranged by Simon B. Kleiner and included papers by Morris Tager of Yale Medical School, Roy E. Mabrey of Boston, A. Markoff of New Haven, Neil W. Swinton of Boston, George Speare of Boston, H. Leonard Bolen of Fall River, Frederick S. Ellison of Hartford and M. Levinsky of Bridgeport. The papers dealt with parasitic infections, rectal polyps, denervation of perianal skin for pruritus, use of anesthetic alcohol and of sulfa crecpryn cream.

The 10th annual meeting of the Society is being planned for Hartford next October when the New York Proctological Society will attend and arrange the scientific program.

### Institute of Living Makes City an Offer

Developing out of the recent controversy over the question of whether or not the Institute of Living shall be exempt from taxation by the City of Hartford has come an offer from the Institute to assume the care of the city's neuropsychiatric patients. These are now cared for at the John B. McCook Memorial Hospital (formerly the Municipal Hospital). The proposal by the Institute will provide for this group of patients better techniques and newer equipment. Some believe it will create a saving to the city's expenditures. The Institute plans, in order to care for these additional patients, to erect a new building at a cost of \$200,000. The offer is predicated entirely on the passage of a bill now before the General Assembly exempting the Institute and other non profit hospitals from the city property tax.



Before acting on the offer from the Institute of Living the Board of Welfare Commissioners referred the offer to the executive committee of the staff of the McCook Memorial Hospital. This committee feels that the offer should be accepted, provided facilities for care of the milder neuropsychiatric cases developing on the wards of the hospital may still be maintained at the hospital. The committee pointed out to the Welfare Commissioners that the number of beds available at present for caring for this group of patients is inadequate and that to move this number of beds to another hospital without continuing facilities for these patients at the McCook Memorial Hospital would not solve the difficulty.

The Board of Welfare Commissioners has postponed action on the offer from the Institute.

### Pharmacists Found Inaccurate

Following a survey made of pharmaceutical accuracy in compounding prescriptions, the Connecticut Board of Pharmacy Commissioners indefinitely suspended the license of one pharmacist. A ten day suspension of licenses with the execution of the suspension indefinitely postponed was imposed in the case of six other pharmacists. Warnings were issued in the remaining forty-seven cases. Ten store owners were warned to put their stores in a sanitary condition satisfactory to the Dairy and Food Commission within thirty days or face the indefinite suspension of their store licenses.

### Dr. Edgar Fauver Memorialized

The physicians and dentists on the staff of the Middlesex Hospital, Middletown, have subscribed over \$1,100 to establish a Fauver Memorial Loan Fund for the Nursing School in honor of Dr. Edgar Fauver. The Nursing School was always one of Dr. Fauver's principal interests. The Loan Fund is to be a self perpetuating memorial and money loaned for student aid is to be returned without interest.

### New Haven Detection Center

With Hartford's Cancer Consultation Service in full swing, New Haven also comes to the fore with a Detection Center, developed with Society funds as an extension of the Tumor Clinic of the Yale School of Medicine. Appointments for physical examinations are made through the Information Center at 817 Chapel Street, New Haven, telephone 6-2421.

## THE DOCTOR'S OFFICE

Robert Dinolt, M.D., announces the opening of an office for the practice of ophthalmology and otorhinolaryngology in the Bradley Theatre Building, Putnam.

Morris L. Dunn, M.D., announces the opening of an office for the practice of medicine at 99 West Main Street, New Britain.

Reginald E. Gillson, M.D., announces the removal of his office to 45 Trumbull Street, New Haven. Dr. Gillson, a dermatologist, has taken over the practice of Edward A. Abbey who has moved to Florida.

Benjamin H. Gottesfeld, M.D., announces the opening of an office for the practice of neurology and psychiatry at 99 Pratt Street, Hartford.

Stuart Joslin, M.D., announces the opening of an office for the practice of pediatrics at 27 Unquowa Road, Fairfield.

Leo G. LaPalme, M.D., announces the opening of an office for the practice of medicine at 158 Main Street, Putnam.

Frederick L. Nichols, M.D., announces his association in the practice of internal medicine with G. Gardiner Russell, M.D., at 179 Allyn Street, Hartford.

### Hartford Hospital Issues Magazine

The first issue of the *Hartford Hospital Bulletin* to appear since the recent war was published in April. It is a monthly magazine devoted chiefly to scientific discussion of medical cases considered at the hospital's weekly teaching clinics.

The April issue includes discussions of lipoid pneumonia by Samuel Rowley, Paget's disease by Ronald S. Beckett, lobular carcinoma, Edward G. Deming, and a report by John C. Leonard. Dr. Leonard will return as hospital director of medical education July 1.

Maxwell O. Phelps is managing editor of the publication assisted by nine associate editors. They are Drs. William F. Prestley, J. Stanley Marietta, Archibald S. Deming, John B. Wells, Edward G. Deming, James W. Short, Leroy H. Wardner, Frank F. Espey and John E. Cartland.

## PUBLIC RELATIONS BEGIN AT HOME

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NEW LONDON, April 3—Dr. Willard J. Morse, president of the New London City Medical Society, has announced that the society will participate with the New London Health Council in sponsoring a four-day health carnival to promote general interest in health problems. The carnival will be held in the New London Armory starting May 13, and will be open to the public from 10 A. M. to 8 P. M. daily.

NEW CANAAN, Jan. 30—The Physician's Association of New Canaan has announced its endorsement of an x-ray survey to be conducted here under the auspices of the Visiting Nurse Association. The mobile x-ray unit of the State Tuberculosis Commission will be used for the survey, and will be parked at the New Canaan Town Hall from March 24 to April 3, inclusive. The survey will provide reference films for family physicians and public health records.

When people at home join their doctors in meeting community health problems, everyone comes closer to an understanding of good medical care

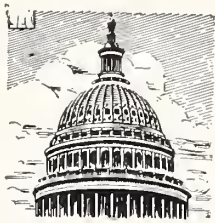
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COMMUNITY EFFORT IS THE SAFEGUARD OF FREE ENTERPRISE

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PUBLIC  
AFFAIRS

NEWS FROM WASHINGTON

New Wagner-Murray-Dingell Bill

The new Wagner-Murray-Dingell bill was introduced into Congress during May. This was to be expected. Hearings on this bill will follow immediately those on S545 (Taft-Ball-Smith-Donnell bill). Hearings on S545 were scheduled to begin May 21. Senator Smith hopes to limit hearings for the two bills to a four week period.

Congressional Investigation Order

The House Committee on Expenditures in the Executive Departments has set up a Subcommittee on Publicity and Propaganda in such Departments. This means at long last there is to be a Congressional investigation of several situations in the Federal Security Agency.

National Cancer Research Commission Bill

S1130 was introduced by Mr. Taft of Ohio for himself and Mr. Smith of New Jersey on April 18. This is a bill to create a National Cancer Research Commission in order to provide for and coordinate research in a supreme endeavor to discover the causes of cancer and means for its prevention; to develop a limited number of research centers; to mobilize in the United States a number of the world's outstanding experts in scientific research in order to utilize their services; and for other purposes. It has been referred to the Committee on Labor and Public Welfare. This bill creates a fifteen-man commission composed of ten eminent scientists, expert in the field of medicine or the basic sciences, and five laymen appointed by the President to serve for a term of five years. The commission shall choose one of its members every three years to act as chairman. The commission shall formulate a program to provide for

and to coordinate scientific research directed toward the discovery of the cause of cancer and means for its prevention. The commission is authorized (1) to make grants for not more than ten public or private research centers in the United States (one of which shall be the National Cancer Institute at Bethesda, Maryland, and others shall be connected with a university medical school); (2) to award fellowships for research at institutions in the United States designated by the commission; (3) to make grants for individual research projects at from one to five years in duration at institutions in the United States designated by the commission; (4) to collect information for publication on studies being carried on in the United States and other countries relating to cancer research, and to promote coordination of researches.

Nothing in the Act is to be construed as authorizing the establishment of any federally owned or operated research facility other than the National Cancer Institute, and nothing in the Act shall be construed as limiting or curtailing the powers, authorities, or duties of the National Cancer Institute. Authority is given the commission to appoint a national administrator of cancer research for a term of four years at an annual salary of \$15,000. An appropriation of \$75,000,000 is authorized for the next five years or until expended.

Apparently this legislation has struck a snag. The Senate Appropriations Committee cut \$5,300,000 from the House-approved cancer budget, leaving \$12,000,000 for the Public Health Service. Groups asking for the creation of a Cancer Research Commission for \$75,000,000 over five years have met Senatorial opposition. There is little disposition to create such a Commission. It is argued: (1) the National Cancer Institute is a going concern and

should receive all Federal appropriations for cancer work; (2) large sums could not be used for cancer research since there is no research in this field and the most that can be done is to train scientists in the hope that years hence they may stumble on the cause of cancer; (3) if cancer work is transferred to the National Science Foundation, S526, which calls for a Foundation of twenty-four members with a paid director, might have a better chance of enactment because legislation dealing with cancer has a popular appeal. The whole situation in Congress seems confused. Pressures have not had the desired effect. In the meantime the Public Health Service is enjoying an increase in the budget for its own activities and a large appropriation for grants. Without proven competence as a fiduciary agency we are told that the National Cancer Institute is to change from research to fiscal activities.

### Army Physicians Pay Increase Sought

S1143 was introduced April 22 by Mr. Gurney of South Dakota. This bill is to provide for the procurement of physicians and surgeons in the Medical Department of the Army, and for other purposes. It has been referred to the Committee on Armed Services.

Commissioned officers of the Medical Corps with less than 30 years' active Federal Commissioned Service shall have their active duty base and longevity pay increased by \$1,200 per year.

Qualified commissioned officers of the Medical Corps of the Regular Army, general officers appointed from the Medical Corps of the Regular Army, and professors of the Medical Department of the Army may be designated as specialists if they are recognized by the Advisory Board for Medical Specialists and by the Surgeon General of the Army. Commissioned Medical Corps officers of the Army, other than those of the Regular Army, may also be designated.

There are to be established in the Medical Department of the Regular Army four professorships in medicine, surgery, neuropsychiatry, and preventive medicine. Persons are to be appointed by the President and will serve at schools, medical centers, teaching hospitals and other Medical Department installations and as consultants to the Surgeon General.

The President is authorized to appoint and commission in the Medical Corps of the Regular Army physicians and surgeons who have been certified as specialists by an American Specialty Board recog-

nized by the Advisory Board for Medical Specialties and by the Surgeon General of the Army.

The Secretary of War is authorized to employ without regard to civil service requirements civilian physicians to serve with the Medical Department of the Army on a salary grade similar to what now prevails in the Veterans Administration.

### Whither the Voluntary Hospital?

Frank Glenn, M.D., associate professor of clinical surgery at Cornell University Medical College, addressed the New England Post-Graduate Assembly last fall on The Possible Role of the Community Hospital in Graduate Training in Surgery. From his paper published in *The New England Medical Journal* has been taken the following poignant paragraph:

The health and death rates of a community are in direct relation to the amount of money intelligently spent on sanitation, preventive medicine, the education of doctors and the others engaged in the care of the sick and the support of medical schools and hospitals. If the people of Boston and the United States want good hospitals, they must pay for them. If they want voluntary hospitals, they must support them through individual gifts, through industrial donations, through the requirement that governmental agencies assume their obligations in full and through modification of legislation affecting them. Only in this way can the flower of our hospital system, the pacemaking voluntary hospital, be preserved.

### A.M.A. Centennial Postage Stamp

Postmaster General Robert E. Hannegan has approved the issuance of a commemorative postage stamp honoring the doctors of America.

The special stamp will be of the three-cent variety and will be placed on sale on June 9 on the occasion of the 100th anniversary of the founding of the American Medical Association.

"In so honoring the American doctor," Mr. Hannegan said, "we are paying tribute to the men and women of medicine who devote their lives to the cause of humanity. Alleviation of pain and suffering and the betterment of mankind is their creed. The contribution which they have made to our national life is one of which all Americans can be proud and grateful."



## Committee on Rural Health Conference

The first meeting of the steering committee to plan for the Rural Health Conference to be held at the University of Connecticut on July 16 was recently held at the Faculty Club, in New Haven.

Following a discussion of preliminary plans, the group agreed to meet again on May 20 to receive committee reports and to develop the program and arrangements. Norman H. Gardner, of East Hampton, chairman of the Society's Committee on Rural Medical Service, presided at the meeting.

Members of the steering committee include: David H. Bates, Putnam; James F. Ferguson, Wallingford; Gaert S. Gudernatch, Sharon; and William H. Upson, Suffield; all members of the Committee on Rural Medical Service; Mrs. Ruth R. Clark, University of Connecticut Extension Service; James A. Dolce, M.D., State Department of Health; Frank M. Jerman, D.D.S., Connecticut Dental Association; Prof. Ira V. Hiscock, Yale School of Medicine; Mrs. Douglas O. Burnham, Connecticut Cancer Society; Mrs. C. Whitfield Gowrie, Connecticut Federation of Women's Clubs; Mrs. Harold Strickland, Connecticut Chapter, American Farm Bureau Federation; Harry L. Page, Connecticut State Grange; Mrs. John J. Whitehead, Parent-Teacher Association of Connecticut; Miss Helen Reed, Connecticut Federation of Rural Youth; Miss Rowena Belden, Connecticut State Nurses' Association; Mrs. Miriam H. Rohde, Connecticut Tuberculosis Association; and Finis Engleman, Connecticut State Department of Education.

## Connecticut Physicians at New England Health Conference

The New England Health Conference this year will be held at the University of New Hampshire, Durham, N. H., June 16, 17 and 18. The preliminary program lists ten speakers from Connecticut as follows:

C. E. A. Winslow, M.D., DR.P.H., on "School Health Education."

Charles C. Wilson, M.D., on "School Health Examination."

Edward J. Ottenheimer, M.D., on "Cancer on a Statewide Basis."

Miss D. Evelyn West of the State Department of Health on "Standard Culture Technique of the Tubercle Bacilli."

Bruno Gerstl of Cedarcrest Sanatorium on "Laboratory Diagnosis of Tuberculosis Infections."

Paul Phelps, M.D., on "Administrative Control of Tuberculosis."

R. C. Edson, M.D., on "X-ray Examinations of Hospital Admissions."

Friend Lee Mickle, sc.D., of the State Department of Health, on "Laboratories."

Stanley H. Osborn, M.D., on "State Health Department Administration."

Ira M. Hiscock, M.D., on "Organization of District Health Units in New England."

In addition three others will serve as chairmen of section programs: Eugene E. Lamoureux, M.D., the program on "Communicable Diseases;" Albert S. Gray, M.D., "Industrial Health and Hygiene;" Earl K. Borum of the State Department of Health, the symposium on "Enteric Infections." Dr. Mickle will also preside at the sectional meeting on "Laboratories."

## Only Two Per Cent Tincture of Iodine Now Official

When the new U.S.P. XIII becomes official in April of this year, the old familiar seven per cent tincture of iodine will be obsolete. In the last Pharmacopeia three iodine antiseptics were recognized. There was the mild tincture of iodine which was a two per cent preparation, and there was the seven per cent tincture of iodine, and finally, a two per cent aqueous solution. The latter has been discarded because it freezes too easily in cold weather. The seven per cent tincture of iodine is also being dropped as an official preparation because it sometimes retards healing due to tissue destruction.

Effective in April, therefore, a prescription for tincture of iodine will call for the two per cent preparation. This is just as efficient as an antiseptic and germicide as is the old seven per cent tincture and it is far less irritating when applied to open wounds. It will not smart or sting as did the old seven per cent tincture.

Physicians who for any reason still want the seven per cent tincture, may obtain it by calling for strong iodine tincture National Formulary VIII.

Iodine is absorbed by the sulfur in the ordinary rubber stopper used in bottles, and the new synthetic butyl rubber stopper is recommended as far superior in iodine absorption resistance to natural rubber or to the ordinary buna rubber.

## Course in Hospital Administration

Yale University has announced plans for the establishment next September of a graduate course in hospital administration, made possible by a grant from the W. K. Kellogg Foundation.

The course will be an integral part of the teaching and research program in the Department of Public Health of the Yale School of Medicine. Dr. Clement C. Clay, newly appointed assistant professor of Hospital Administration, will act as director of the hospital administration course.

Present plans for the course call for the utilization of facilities of the Grace-New Haven Community Hospital, appropriate university departments and schools, and hospitals and other agencies in the New Haven area.

The program of instruction will include basic background subjects as well as those related specifically to management of hospitals. Through lectures, seminars, and actual practice work in hospitals, the students will be introduced to the function of each department of the hospital organization.

They will also acquire a knowledge of such subjects as admitting procedure, institutional house-keeping, laundry operation, plant maintenance, nursing service and education, medical staff relations, and the operation of the x-ray department, laboratories, pharmacy, and other facilities.

The total period of training will be at least 21 months, of which not less than nine months will be spent in residence at the university. Thereafter the student will become an administrative intern or resident in a hospital approved by the University for supervised practical training under an experienced administrator. Upon successful completion of the course, the student will be a candidate for a master's degree.

Three classes of students will be eligible for admission to the new course: Doctors of Medicine, graduate nurses who have a bachelor's degree, and individuals who have a bachelor's degree without special training in medicine or nursing. Some practical experience in hospitals or medical care agencies is a prerequisite.

## Dr. Francis G. Blake Elected

Francis G. Blake, dean of Yale University School of Medicine, has been honored by election as second vice-president of the American College of Physi-

cians. Reginald Fitz of Boston is the new first vice-president.

## Dr. Van Antwerp Leaves Connecticut

Lee D. Van Antwerp, formerly a member of the JOURNAL board, has resigned from the staff at Undercliff Sanatorium to accept a position with G. D. Searle & Company, a large pharmaceutical house in Chicago. Dr. Van Antwerp had been a member of the staff at Undercliff since 1931 and at the time of his resignation was senior physician. He served with the U. S. Army Medical Corps first as Major, then as Lieutenant Colonel, during World War II, and was a member of the JOURNAL board during the years 1942-1943 and 1946-1947. His many friends wish him success in his new field.

## New Specialty Board

The Advisory Board for Medical Specialties is recommending a new specialty board of physical medicine, which, if approved by the Council on Medical Education and Hospitals of the American Medical Association, will become an affiliate board of the American Board of Internal Medicine. Approval of the recommendation now rests with the Council, which will discuss and decide the issue at its June meeting in Atlantic City.

## Organized Study of Nursing Problem

As a basic step in overcoming the acute shortage of registered nurses and other problems in the field, the National Nursing Council, representing 14 leading professional organizations, is undertaking an intensive study of the registered nurse's real job and the changes in education that she requires for it. The study is being financed by a grant of approximately \$28,000 from the Carnegie Corporation of New York.

Dr. Esther Lucile Brown, director of the Department of Studies in the Professions of the Russell Sage Foundation, has been appointed to make the study for the Council. Dr. Brown is the author of "Nursing As a Profession," "Physicians and Medical Care" and other publications for the Foundation. She has also served on the boards of several health organizations.

The study will focus on the following overall problem: "How should a basic professional nursing school be organized, administered, controlled and



financially supported to prepare its graduates adequately to meet community needs?"

In analyzing existing nursing schools, it will cover such questions as: who controls the schools and how are they administered and financed; and how do economic factors affect the character of the curriculum, the size and qualifications of the faculty, admission requirements and physical facilities? For the purposes of the study, the Council will use data on American nursing schools secured from the United States Public Health Service and the National League of Nursing education.

### Nursing Problems in the Small Hospitals

Rural areas in Connecticut have hospitals with as few as 22 to 30 patients. *Nursing News*, published by the Connecticut State Nurses Association, informs us that these small hospitals may have a director of nursing with six staff nurses to assist her, two on each eight hour schedule. Sometimes the director may be lucky enough to have an assistant director—who manages the operating room as her major job. The directors of nursing in some of these little hospitals are versatile people—you may find them anywhere from x-ray to bedside. You may find them doing anything from buying rubber tubing from a salesman to interviewing an applicant—from pacifying a newly admitted youngster to hunting up a nurse for "3 to 11"—and winding up with the decision to cover the schedule herself.

The major drawbacks to a nurse's happiness in rural hospitals seems to fall under these headings:

1. Lack of recreational facilities.
2. Lack of shopping facilities—tied in with lack of transportation.
3. Dearth of escorts for the young nurses.
4. Lack of opportunity for professional advancement.
5. Lack of facilities for staff or personal educational programs.

In addition, many hospitals, rural and otherwise, have not yet made adjustments in personnel policies to meet present day trends in salaries and hours. This, at least, is a possible and promising avenue of progress for the rural hospitals. It might help in the staffing of those institutions where the nurses have been habitually underpaid.

There seems to be no question that the small rural hospital is a vital necessity to the area it serves. It

therefore follows that the community must undertake a dynamic program to make rural life attractive to quality workers in all fields. The hospital management has some responsibility in informing, interpreting and initiating constructive action.

### Chest X-ray Survey in Milwaukee

The biggest mass chest x-ray survey ever conducted among the civilian population of the United States is now under way in Milwaukee, as a part of the government's ever increasing fight against tuberculosis, and other pulmonary diseases.

Every one of the more than 600,000 citizens of Milwaukee is being offered a chest check-up during the survey, conducted by the U. S. Public Health Service, in cooperation with the Milwaukee Health Department and Tuberculosis Association. Such surveys to determine the incidence of disease have been carried on in other towns and cities, but this is the first time one has been undertaken in one of the country's largest metropolitan areas. The survey continues through April 15.

Mobile equipment consisting of special mass chest x-ray units, using the recently perfected 70-millimeter automatic Fluororecord cameras, is set up throughout the city in factories, department stores, residential sections and community centers. E. R. Krumbiegel, city health commissioner, has mobilized the forces of the entire city health department to insure the success of this survey.

Every citizen who wishes an x-ray check-up gives his name and address and voluntarily steps in front of the x-ray fluoroscopic screen to be photographed. The entire procedure takes only a few moments. If the physician examining the photographic negative detects signs of tuberculosis, the person is privately notified. By this simple method health departments have been able to discover scores of persons with early chest diseases in time for successful treatment. This protects the individual and the community.

Milwaukee was chosen for this pioneer work because its numerous clinics and physicians make possible a long range follow-up program. The experience in Milwaukee will provide data for statistical medical research in the course of tuberculosis in a large American city.

Public Health Service officials said that after completion of the Milwaukee survey it is planned to institute a similar full scale x-ray examination of the population of Minneapolis.

## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*

EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven

JOSEPH N. D'ESOP, New Haven

### Prescriptions For Veterans

95 Pearl Street, Hartford 4, Conn.

May 7, 1947

To the Editor:

It has been brought to the attention of this office that certain difficulties have occurred in the proper administrative procedure of handling prescriptions issued by our Fee Basis Doctors for authorized treatment of service-connected disabilities.

In furtherance of our endeavors for closer correlation of the various factors pertinent to adequate medical care of the veteran population, and to decrease impediments to sound administrative procedure, we are herewith enclosing a short statement for dissemination to the medical profession. We hope that it will be possible to include this in your next issue of the CONNECTICUT STATE MEDICAL JOURNAL.

We are transmitting a similar release to the Connecticut Pharmaceutical Association, and, in addition, we shall send similar notices to all our participating physicians and dentists.

Thanking you for your kind cooperation, we beg to remain,

Sincerely yours,

SAMUEL A. SCHUYLER, M.D.,  
Chief Medical Officer.

Certain difficulties relative to the proper administrative functioning of the State Pharmaceutical Plan for filling prescriptions have come to the attention of this office. There is an indication of an unwillingness to renew or to continue agreements to supply prescription service because of major losses for services rendered in good faith, as a result of physicians signing their authorization legend without actually holding an authorization for the treatment of that particular veteran. Prescriptions so endorsed and filled by pharmacists are necessarily rejected at the Regional Office, with a resultant financial loss to pharmacists from conditions entirely beyond their control. In order to eliminate the difficulties which have arisen, the following information is brought to the attention of participating physicians for such

corrective action as may be deemed necessary:

1. Signing the legend "I am authorized to treat and prescribe for the above named VA beneficiary" on prescriptions, when the physician is not authorized or has not requested actual current authorization covering the specific service connected disability, may constitute a violation of the Federal Statutes. This may further require reference to the Department of Justice for prosecution. These prescriptions, although filled in good faith by participating pharmacies, cannot be paid by the VA, and therefore results in a loss, of the cost of the Rx, to the pharmacy.

2. When necessary to prescribe for a VA beneficiary, for whom authorization has not been obtained, such prescriptions may be (a) Mailed to the Hartford Regional Office for filling or (b) Marked "Emergency" for filling locally.

3. In marking prescriptions "Emergency," physicians must not sign the standard authorization legend. Prescriptions marked "Emergency" are not subject to filling without cost to the veteran by participating pharmacies under the terms of the Pharmaceutical Association agreement. Prescriptions marked "Emergency," if presented to private pharmacies, must be arranged for, as regards payment, on an individual basis by the veteran and the pharmacist. The claim for reimbursement may be filed by the veteran, or claim for payment filed by the pharmacy, with the VA, if the disability for which the prescription is issued is service connected.

We wish to take this occasion to express our appreciation for your interest and cooperation in the rendering of essential medical care to our veteran population.

SAMUEL A. SCHUYLER, M.D.,  
Chief Medical Officer.

### Old Farms Convalescent and Pratt General Hospital Close June 30

Closure by June 30 of two Army hospitals—Old Farms Convalescent Hospital at Avon, Connecticut,



and Pratt General Hospital at Coral Gables, Florida—was announced recently by the Office of The Surgeon General.

In accordance with Medical Department policy, Army hospitals have been closed as rapidly as the decreasing patient load has permitted. At the peak of the war the Army operated sixty-five general hospitals and thirteen convalescent hospitals with a maximum patient load of over 245,000 patients. With the closing of Old Farms and Pratt, the Army will have thirteen general hospitals in operation, with approximately 28,000 patients, and no convalescent hospitals.

Old Farms Convalescent Hospital has been a center for the rehabilitation of blinded patients. Patterned after the famous St. Dunstan's of England, the rehabilitation program which has been carried on at Old Farms has generally been regarded as the finest ever provided for blinded patients and is now being followed in other blind centers because of its outstanding success.

Activated in June 1944, Old Farms Convalescent Hospital will have given reorientation to nearly 1,000 of the 1,100 blinded casualties of World War II by the time it is closed on June 30, 1947. Colonel Frank H. Thorne commanded Old Farms from the time of its activation until October 1945, when he was succeeded by Colonel Charles A. Pfeffer.

Pratt General Hospital, formerly the Miami Biltmore Hotel, was taken over early in the war as a regional and convalescent hospital for Air Corps personnel. It became an Army general hospital on May 15, 1946 and now is caring for approximately 1,000 patients. The patients in this group who will require hospitalization after June 30 will be transferred to other Army general hospitals. Colonel Clyde M. Beck has been in command of Pratt since it became a General Hospital.

### Laxity in Health Education

Sharp criticism of present day health education was voiced by Dr. Frank J. O'Brien, associate superintendent for the New York City Board of Education, when he addressed the second annual convention of the Connecticut Association for Health, Physical Education, and Recreation, held at New Haven's Hotel Taft on April 17 and 18.

"We in health education have been unpardonably negligent to the point of laziness," he declared, and added that "because we have been indifferent or ignorant, we have not learned from our failures." This he labelled as the "cardinal sin" of health education.

Charging that "educators have never been really interested in health education," he told his audience that "the curriculum of the average public school student is burdened with such a galaxy of subject matter that little room is left for health subjects."

"Someday somebody will wake up and lay at our door the responsibility for good health," Dr. O'Brien prophesied, and declared that the teaching of subjects to increase student knowledge and develop special skills "does not necessarily lead to healthful conditions."

"It is possible for some of our youngsters to go through high school today and get no real education in health. Are we interested only in meeting college requirements, when less than 20 per cent of our students are going to college? Our school children don't want an outmoded program—they can't use it to lead useful lives in a democratic society."

Attacking the practice of "100 per cent promotions" which he charged exists throughout a large sector of public education, he pointed out that, although students should be encouraged to pursue advanced studies, he does not agree with the wholesale promotion of backward students merely "to get rid of these problems on a higher level." He emphasized that training of the memory, and not training of the mind, is too often the undesirable goal of many practices in modern education.

Turning to the effects of education upon the disturbed conditions in the modern world, the speaker stated that "the trouble with the world today is no different from yesterday, except that it is on a larger scale."

"Some of the problems which we face today are serious. Yet, many people seem to be merely playing with their solution. This is like teaching words to a child, the literal acceptance of which leaves him with no feeling for the rich content of the mind."

Attended by approximately 300 educators, parents, physicians, teachers, and nurses the convention included several panel discussions on health education problems and a visitation to the Gesell Clinic of Child Development at the Institute of Human Relations, Yale University.

## ASSOCIATION OF CONNECTICUT TUMOR CLINICS

### RECENT ADVANCES IN THE DIAGNOSIS AND TREATMENT OF CANCER OF THE CERVIX

GRAY H. TWOMBLY, M.D., *New York*

It is a great pleasure to be here today to talk to so many people as interested in cancer as are the members of the Connecticut State Tumor Clinics. It is particularly pleasant to come here to Norwalk to talk about cancer of the cervix uteri because, in a way, we are thereby commemorating Dr. William Stone who founded and carried on the tumor clinic here and who was first and foremost a gynecologist. Were he alive and with us today, I think there is no topic in which he would be as keenly interested as in this one. His death is a grievous loss to us.

The purpose of this talk can be divided in two, first to bring to you with renewed emphasis the importance of early diagnosis of cancer of the cervix and the simple methods whereby this may be obtained, and, secondly, to review for you our present methods of treating this disease. These two aspects will be described not as though they were fixed, crystalized masses of knowledge, but rather as progressive, growing opinions and facts constantly becoming clearer, but as yet far from absolute truth.

Cancer of the cervix uteri is one of the most important forms of cancer because it is, in a sense, a surface lesion, it is easily diagnosed in most cases by inspection, and it is curable in a fair proportion, probably about 30 per cent, of all cases. In frequency of incidence in New York State, it ranks second to cancer of the breast, but is more common than the most frequent type of cancer in the male, cancer of the skin.<sup>1</sup> The incidence per 100,000 of the population is 60 for the breast, 34.3 for the cervix, and 29.2 for the skin in males. Cancer of the stomach in males comes fourth, 27.1. Cancer of the cervix seems to be about three times as prevalent as cancer of the corpus of the uterus.

In 1937 the present standard nomenclature, or classification, for cancer of the cervix was adopted by the League of Nations Health organization.<sup>2</sup> It

can be stated briefly as follows: All cases in which the cancer is limited to the cervix, no matter how bulky, are called Stage I. When the tumor extends into the parametria or involves the upper one-third of the vaginal mucous membrane, it is called Stage II. If there is fixation of the cancer to one or both pelvic walls or a fixed metastasis against the pelvic wall or growth of tumor in the lower two-thirds of the vagina, it is Stage III. Stage IV is defined as actual invasion through the mucosa of the urinary bladder or rectum or extension or metastasis of the tumor outside the true pelvis.

It is readily understood that only in Stage I, and in relatively few of these, is there any difficulty in making a diagnosis, provided one goes to the trouble of *feeling* the cervix and *looking* at it with a vaginal speculum. Certainly the large ulcerated growths which involve the entire cervix or part of the vaginal wall can hardly be missed by even the most inexperienced.

How many cases, then, present any difficulty in diagnosis? From 1932 to 1937 only 16 per cent of all the primary cases coming to the Gynecological Service at Memorial Hospital were classified as League of Nations Stage I.<sup>3</sup> In 1943-44 a few more early cases were seen, 20.3 per cent.<sup>4</sup> Since most of these Stage I cases were quite obviously cancer as determined by casual inspection, it is safe to say that less than 10 per cent of all women having cancer of the cervix present any diagnostic problem to the doctor who takes the trouble to do a proper pelvic examination. One can hardly condemn too strongly the physician who is willing to prescribe some form of medication for irregular, profuse, or prolonged periods, or intermenstrual spotting in the patient over thirty without such an examination.

Of this possible ten per cent of cases which present any diagnostic problem, most will show some sort of

*Papers by Drs. Twombly, Bradley, Simon and Connolly were presented at a meeting of the Connecticut Association of Tumor Clinics, Norwalk, November 14, 1946*



suspicious ulceration or erosion of the cervix. If the examining physician has available along with his glove, speculum, and light, a serviceable biopsy forceps, a positive diagnosis in these cases can be made on the first examination. This instrument should be long enough to work easily through the vaginal speculum. If the handles are offset at an angle to the blades, one can see just what one is doing. The hand does not get in the way of direct vision down the narrow tube formed by the speculum and vagina. In addition to these attributes, the forceps should have sharp cutting edges on the cups so that the eroded tissue can be biopsied with as little crushing as possible.

More important than any new method of diagnosis and perhaps even more important than the education of the public to seek frequent medical examinations, is the inculcation in the mind of every general practitioner, surgeon or gynecologist of the importance of feeling and inspecting the cervix and of taking a biopsy from every suspicious erosion. If a suitable biopsy forceps is immediately available by one's hand on the examining table, this taking of biopsies is a simple, natural, easy thing to do. If one must get the materials for a biopsy from some distant place or send the patient into a hospital to have it done, too often the temptation is to pass up unbiopsied as erosions the early lesions and thereby fail to make, or unduly delay, the diagnosis of early cancer.

In making biopsies of the cervix, the Schiller test in which the cervix is painted with Lugol's iodine solution is often helpful in indicating suspicious areas.<sup>5</sup> The normal cervix when treated with this solution turns a deep mahogany brown or black. Areas of early cancer remain white and unstained. The test is not diagnostic, for the same failure to stain is seen with leukoplakia and occasionally when no demonstrable microscopic lesion is present. Of course, eroded areas also fail to take the iodine, remaining their original pink or red color. In spite of these limitations, the procedure is a useful one to call one's attention to the abnormal areas that may be present in the cervical mucous membrane.

We come now to the most recent attempts to refine the diagnosis of cancer of the cervix, examination of the vaginal smear. In 1928 Papanicolaou<sup>6</sup> demonstrated the presence of identifiable cancer cells in the vaginal secretions of patients with cancer of the cervix, and in 1941<sup>7</sup> and 1943<sup>8</sup> these observations were elaborated by Papanicolaou and Traut. Since that time the notion that this method might be

applicable to the early diagnosis of cancer of the cervix and might form a useful screening test for large numbers of women has gained ground. Recently the State of Connecticut has appropriated a sum of money to try out the method on a small scale in Hartford.

There is no question that the experienced cytologist who has had experience with this method can make a diagnosis of cancer of the cervix in most cases by the vaginal smear. However, it seems to be a method which works well only in the hands of experts, and even here occasional false positives are obtained. Dr. Marchetti of the New York Hospital, speaking at the Graduate Fortnight of the New York Academy of Medicine, said that in their experience 9 per cent of the smears thought to be positive came from patients without further evidence of cancer. His recent figures are 5 per cent of such false positives.<sup>9</sup> Dr. J. V. Meigs<sup>10</sup> in his last paper says that his "number of errors for false positive smears is *now* at 2 per cent." These figures are cited to emphasize one of Dr. Meigs' conclusions, that a positive smear is not an indication for therapy, but for further biopsy. It is notably difficult to interrupt postradiation smears, many of which look positive when there is no clinical cancer.

To teach the average woman to take a vaginal smear from herself would seem as difficult, or more so, than to examine her with light and speculum and biopsy any suspicious area seen. It would seem doubtful whether large numbers of early cancers could be found in this way, particularly in light of the fact that cancer of the cervix seems to occur with greatest frequency among the poor and dirty and ignorant.

Where the method would seem to have great promise is in picking up cancers of the endocervix which may be almost asymptomatic and not possible of visualization by ordinary examination methods. Some work in our hospital suggests that direct smear from the diseased cervix gives a much better chance of diagnosis than does the usual specimen taken from the posterior fornix. Perhaps the direct smearing of any suspicious area seen on the cervix, together with a sampling of mucous from the cervical canal, may pick up tumors too inconspicuous for formal biopsy. If false positives in such a procedure are found to be low, the smear technique will have added greatly to our diagnostic abilities.

One cannot turn from this discussion of vaginal smears without a word about "carcinoma-in-situ."

Certainly as one reads over the reports of the enthusiastic advocates of this technique, one gains the impression that many of the cases which show positive slides but no gross changes on inspection of the vaginal mucous membrane turn out to have this intracellular type of change with little or no evidence of invasion. Is the hyperchromatism, the nuclear irregularity, and the loss of keratinization that one sees in this disease evidence of the beginning of true invasive cancer? Many gynecological pathologists answer "yes," but when one recalls that this diagnosis was not made twenty years ago, the question of what happened to patients with these changes, treated perhaps by simple cauterization, presents itself. This type of histological change has been recognized for too short a time and its natural history when untreated has been too little studied for us to say with any great assurance what proportion of such cases will evolve into classical invasive carcinoma and how long it will take.<sup>11</sup>

Vaginal smear by uncovering more and more of these cases may give us soon a much clearer concept of the true nature and course of this disease.

The second half of this paper will be concerned with the progression in methods used for the treatment of cancer of the cervix at Memorial Hospital. From 1918 to 1926 treatment consisted of a vaginal applicator or bomb designed by Bailey<sup>12</sup> and Quimby and used in connection with a frame for the legs ("the bomb board") so that the radium could be clamped in three positions to give its chief beam of radiation directly at the cervix or into the right or left parametrium, 1000 mchrs. in each direction. In addition to this, radium was placed in the cervical canal for 1500 to 3000 mchrs., unfiltered glass radon seeds were inserted into the cervix for 200 to 2000 mchrs., and external radiation was given with a radium pack to six positions around the pelvis at a distance of 4 cm. from the skin, total dose 9,000 to 18,000 mchrs. In 1922 the radium pack was replaced by low voltage roentgen therapy (140 K.V.) at 30 cm. T.S.D. 400 r to each of four fields.

In other words, during these years the depth dose delivered either by radium pack or low voltage x-ray to the parametria was probably too little to be effective, and the 22.5 per cent cure rate represents the results one can expect by treatment of cervical cancer with radium.<sup>13</sup>

From 1928 to 1931 external irradiation to the pelvis was given by high voltage therapy, 200 K.V. peak 1.5 mm. cu. filtration at 50 cm. T.S.D. The

daily dose was 750 r. Four ports were treated, each receiving only one exposure. Sometimes a second cycle was given two to three months later. Each patient received also the treatment with radium to the cervix itself devised by Bailey, though the bare glass seeds were later replaced with gold one and finally given up altogether. In later years 1,500 mchrs. to one direction was given with the bomb and 3,000 mchrs. with a radium tandem in the cervical canal. When the results of this type of treatment in 551 cases were reviewed by Healy and Frazell<sup>14</sup> in 1937, the five year survival rate proved to be 27.7 per cent.

In increasing the parametrial dose of external irradiation by raising the kilovoltage and filtration and backing the tube away from the patient, the cure rate had been raised from 22.5 per cent to 27.7 per cent (i.e., 23 per cent) even though the radium dosage to the cervix itself had been kept constant.

The next change in method was suggested by the studies of Arneson and Quimby in 1934<sup>15</sup> who showed that irradiation of the pelvis through six fields at 70 cm. T.S.D. would increase the dose to the parametria very considerably. Under Arneson's direction, in 1933 favorable cases of cancer of the cervix began to be treated with these factors, while the daily dose was cut down to 200 r. to each of two fields. The total dose per port, however, was greatly increased, i.e., to 2,000 to 2,400 r.

In 1940 an analysis of ninety-nine cases treated five years or more previously by the "divided dose" type of technique was compared with the cure rate obtained by the concomitantly used "massive dose" technique, 750 r to each of four ports.<sup>3</sup> The cure rate for this divided dose therapy was 35.4 per cent as compared with 27.7 per cent—28.5 per cent for the older type of treatment. During the years 1935 to 1937, another type of divided or multiple dose therapy was tried out in which each of six pelvic ports received 100 r. at the first cycle of treatment, 150 r on the second, 200 r on the third, and so on to 350 r. The last cycle was repeated, making a total of 1700 r. per port. This method, however, proved inferior to the other types of external therapy.

In summary, then, our experiences at the Memorial Hospital suggest that 22.5 per cent of all cases of cancer of the cervix coming to our clinic could be cured by radium alone, that when we add single massive doses of roentgen therapy to four pelvic portals, this cure rate rises to about 28 per cent. If



instead of giving 750 r once to each of four ports at 50 cm., we give 200-250 r eight or ten times to each of six ports at 70 cm. and follow with radium therapy, we may expect a 35 per cent five-year cure rate.

The last five-year figures published from our clinic are those obtained from cases treated from 1932 to 1937,<sup>3</sup> inclusive. Since then several innovations have been tried, definite conclusions on the latest of which must still be held in abeyance pending a longer period of follow-up examination.

When the possibility of improving still further the five-year results in cancer of the cervix was discussed in 1942 with the Physics Department at the hospital, it was pointed out that on theoretical grounds at least the vaginal bomb was an ineffective method of applying radiation. In this apparatus, the radium was confined in a small cavity hollowed out of the front of a pear-shaped mass of lead and this was thrust against the cervix and constituted almost a direct contact application. Admittedly most of the failures to cure this disease are due to persistence or recurrence of cancer in the parametria or pelvic lymph nodes. Because of the working of the inverse square law, a cauterizing dose to the surface of a cervical cancer given by the bomb will provide very little radiation to the pelvic lymph nodes five to six cm. away.

In 1942 and 1943, therefore, Nolan and Quimby<sup>16</sup> undertook to work out what arrangement of radium in the form of intracervical tandems and parametrial radium needles would give the most uniform distribution of radiation throughout the widest area in the pelvis where cervical cancer was known to grow. They studied eight different arrangements of tandem and needles including that advocated and used so successfully by Pitts and Waterman.<sup>17</sup> A distribution described by them as arrangement VIII was shown from the physical point of view to be the most desirable. It consisted of the introduction of four 2-cm. needles directly into the cervix, four 3-cm. needles into the bases of the parametria, angled outward slightly, and four 4-cm. needles thrust into the lateral fornices at a 30° outward angulation. The total dose to be delivered by these needles was proposed to be 4,400 mghrs., while a tandem in the cervical canal would add 3,600 mghrs., or a total of 8,000 mghrs.

It is always difficult to be sure one knows what his results mean. Different men working in different clinics, no matter how careful or honest their ob-

servations, may come to entirely opposite conclusions. It is often hard for the enthusiastic clinician to compare even his own findings from year to year. With some of us, at least, the temptation to feel that the method we are following at the moment is certainly the best we have ever used is unavoidable. If statistics seem to point to better results obtained by an older or discarded method, we are apt to discount them, feeling that the proportion of advanced and early cases must have changed.

In an attempt to get as objective a study as was possible and free our work as far as we could from the criticism that good results were due to favorable material or vice versa, it was decided to try out the suggestions of Nolan and Quimby by dividing the available clinical material into two comparable groups, one to be treated with needles, and the other with some method to replace the bomb and give increased dosage to the parametria. Taylor suggested for this later group that roentgen treatment through lead-lined tubes or cones introduced into the vagina be used.

For two years, then, every case of primary cancer of the cervix which entered the clinic was examined and classified by one of two examiners into its League of Nations Stage. In each stage, cases were alternately placed by a secretary into Groups A and B. Thus, as nearly as we knew how to do it, strictly comparable groups were obtained, each containing an equal number of early and advanced cases. Each case received the same treatment as far as external roentgen therapy to the pelvis was concerned. Each case also had 3,000 mghrs. of radium inserted into the cervical canal. The only variable factor, then, was whether radium needles had been inserted into the parametria or whether these regions had been treated through the vagina with high voltage roentgen therapy with a vaginal cone. The later treatment consisted of 500 r four times to the cervix direct through a cone 4 cm. in diameter (140 K.V. 35 cm. T.S.D.), and 750 r four times through a 3 or 3.5 cm. cone into each fornix.

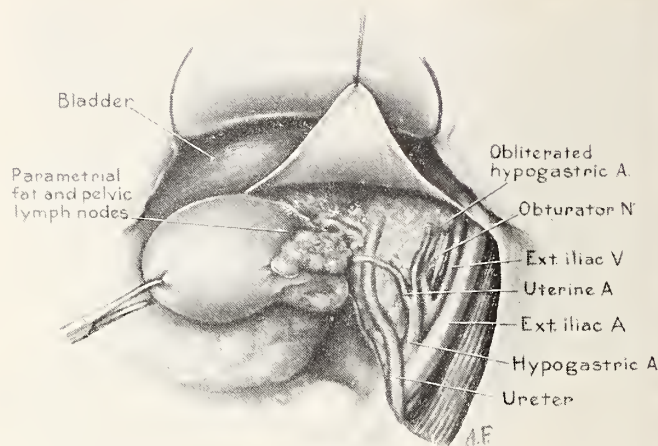
At the end of 1944,<sup>4</sup> ninety-four cases of cancer of the cervix had been treated with external roentgen therapy, radium in the cervical canal, and parametrial radium needles according to the suggestions of Nolan and Quimby. One hundred and thirteen cases had been treated with external roentgen therapy, radium in the cervical canal, and intravaginal roentgen therapy given through cones. Before the conventional five years had elapsed, it was very obvious

that in our hands the second method gave much better results than the first. Nine months after the last patient had been treated, 53 per cent of those on whom needles were used were dead, while only 34 per cent of those treated with intravaginal cones had succumbed. The complications from diarrhoea, rectal bleeding, stricture and fistula, both rectal and urinary, and from pain and local necrosis were much less severe also in the latter group. It was concluded that in our hands the use of interstitial radon needles is ineffective and dangerous as a method of controlling cervical cancer.

This clinical experiment is cited in some detail because the method of comparing similar groups in a single clinic appeals to us as one of the most reliable methods of reaching valid conclusions in such a difficult field as cancer therapy.

At the present time we are using this method to compare what at present seems the best method of radiation therapy, divided dose treatments around the pelvis, intravaginal roentgen therapy with cones and intracervical radium, with radical surgery. To do this, all cases of primary carcinoma of the cervix that come to our clinic are examined and classified as to the extent of their disease. By definition, only those called Stage I or II are operable as far as the local extent of the cancer is concerned. The Stage I cases in which the disease seems to be confined to the cervix are alternately classified as in Group A or Group B. The same is done with the Stage II cases. Those placed in Group B are treated by radiation therapy alone. In Group A, those patients who are constitutionally fit for radical surgery are first given four treatments with a 4-cm. intravaginal cone aimed directly at the cancer, each treatment giving 500 r (measured in air). This procedure is designed to clear up some of the infection that is usually present in these tumors.

After this intravaginal treatment has been given, a radical Wertheim operation is performed. By this is meant first the complete dissection of the pelvic lymph nodes, as illustrated in the accompanying figure. We recognize three main groups of nodes, those along the external and common iliac arteries, the hypogastric nodes along the hypogastric artery, particularly the one that is almost constantly found nestled in the bifurcation of the iliac artery, and the obturator nodes in the obturator foramen. Removal of these nodes exposes the obturator nerve. Care is taken to remove as much of the utero-sacral ligaments as possible, since cancer of the cervix grows



by direct extension into these structures rather early. The operation is completed by removing the uterus and parametrial structures with a wide vaginal cuff, i.e., at least 2 cm.

Many of the cases done at the Memorial Hospital have been closed by reconstructing the pelvic floor without drainage and have been out of bed on the first postoperative day. There has been no operative mortality, but considerable morbidity from interference with bladder function. The treatment has been completed by a course of external roentgen therapy to the pelvis when healing is complete.

Since the first radical Wertheim operation in this group was performed in 1944 and only 42 have been done to date, there is little point in trying to draw any conclusions as to the ultimate value of this method of treatment.

Certain comments should be made however. Why have we taken up a form of therapy so thoroughly tried in the past and so completely discarded in recent years? One reason is that there seems to have been a sudden revival of interest in this surgical approach throughout the country with a tendency for surgeons to choose only the most favorable cases for operation and to report their results uncritically. It seemed to us that if careful comparison were made in one clinic between surgery and radiation therapy in strictly comparable groups, a worthwhile judgment of the value of surgery might be made. So far in our clinic we are still inclined to feel that radiation therapy will show a higher cure rate even in early cases.

Our experience with the radical operation shows that with modern transfusion methods and the use of antibiotics the high mortality of the past is no longer



a factor to be feared. Surgery, were it to be proved more effective than radiation, is still far from the whole answer in cancer of the cervix, however. Many cases are too advanced to permit it, and many localized tumors cannot be removed because of the obesity, age, or general condition of the patient. Our operability so far has been 39 per cent of all cases.

One thing has emerged of great value from this recent surgical experience. We have added to our therapeutic armamentarium one more method to be used under special conditions. For instance, four cases which had failed to respond to roentgen and radium therapy but in which the cancer was still localized, apparently have been cured by radical surgery. A patient who was three months pregnant in whom radiation therapy would have given prolonged morbidity with abortion and questionable control of the tumor, was treated with a minimum of discomfort and hospitalization. A person suffering from pyometra and radiation metritis in whom pre-operatively the likelihood of persistent disease made therapy questionable, was quickly relieved of pain and restored to health.

In conclusion, I hope that I have interested and instructed you somewhat in this, to me, most important and fascinating field of clinical cancer research. As I have already remarked, our knowledge of the treatment of cancer of the cervix is constantly growing. An endeavor to improve our results by careful study of new methods is the only thing which will keep it so.

#### SUMMARY

1. Cancer of the cervix uteri is the second most common form of cancer.
2. At least 90 per cent of cases can be diagnosed by the physician who is willing to routinely feel, inspect and biopsy the cervix.
3. A biopsy forceps is more important in making an early diagnosis of cancer of the cervix than is a knowledge of how to take or examine vaginal smears.
4. Vaginal smears are apt to prove of great value in diagnosing intra-epithelial carcinoma (carcinoma-in-situ) and endocervical cancer.
5. A study of the evolution of radiation methods used at the Memorial Hospital suggests that the most effective form of treatment consists of multiple high voltage roentgen treatments around the pelvis to the limit of skin tolerance given at a target distance of at least 70 cm., accompanied by direct roentgen therapy to the cervix and parametra given through suitable intravaginal cones, and followed by the

application of radium in the cervical canal. Such methods ought to give an over-all cure rate of about 35 per cent.

6. Recent experiences with radical surgery show this method to be feasible with a low operative mortality. They have yet to prove it superior to roentgen therapy and radium.

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## CONNECTICUT CANCER SOCIETY

### Connecticut Cancer Drive Passes Goal

In stronger terms than in any previous year, the people of Connecticut have demonstrated their generosity in supporting the annual Cancer Campaign, by placing the fund undertaking well beyond its objective.

Local returns reaching campaign headquarters from all parts of Connecticut, at the date this magazine went to press, indicate that the 1947 drive will surpass the \$290,000 mark achieved a year ago, by a wide margin. In that year, Connecticut citizens contributed more per individual to the cancer cause than the residents of any other single state. According to Harry F. Morse, chairman of the Connecticut campaign, that feat is once more expected to be duplicated this year.

Mr. Morse, in a statement to the CONNECTICUT STATE MEDICAL JOURNAL, said that the wholehearted backing of Connecticut citizens points out "the eagerness with which the people of this state desire to see cancer's hold on humanity wrested and the extent to which our citizens endorse the plan of attack formulated by the American Cancer Society and the Connecticut Cancer Society."

Sixty per cent of the funds contributed will be channeled into the research, education and service to patients sponsored throughout the state by the Connecticut Cancer Society. The balance will be used to bolster the national endeavor directed against cancer by the American Cancer Society.

Mr. Morse praised the splendid assistance of Katharine Jackson, state campaign vice-chairman, in aiding with the organizing of individual appeals in 169 communities, a record attainment. Quotas ranged from \$42 in Union, Connecticut, to \$48,501 for the Hartford area. He described the campaign planning of local committees as "most thorough and most enterprising in character."

"It was a cooperative undertaking," he said, "in which city officials, individual volunteers, every major service group, Grange units, Boy Scouts, Girl Scouts, labor groups, pharmacists throughout the State, industrial establishments, Federal workers and

school groups joined with a resolution to strike effectively against cancer—and succeeded outstandingly in their task."

### Cancer Current Literature

The Medical Library of the American Cancer Society is publishing in mimeographed form a periodical annotated list of references to articles in the cancer fields appearing in the medical research journals issued during the previous month. This list is intended as a bibliographical record.

### Toxicity of Vitamins

In *Nutrition Reviews*, (February 1947) may be found a review of research results on the toxicity of vitamins. In summing up, the editor informs us that the general statement may be made that the vitamins are relatively non toxic. For those which have been shown to produce death or evidences of toxicity, the ratio of the quantity required daily to maintain optimum nutrition to the lethal or toxic dose varies from 1:600 for 2-methyl-1, 4-naphthoquinone to 1:60,000 for pyridoxine. This ratio is 1:2000 for vitamin D, 1:5000 for niacin, 1:7500 for vitamin A, and 1:25,000 for thiamine. Sufficient latitude in dosage seems to exist for each of the vitamins to preclude all effects from administration to man for nutritional purposes. Yet these substances are readily available and are often administered in quantities far exceeding daily requirements. Evidences of hyper-vitaminosis A, D, and K have been observed in man and are recorded in the literature. It is important, therefore, to keep in mind that toxic doses can and have been given.

Certain of the vitamins may possess pharmacologic actions which are not apparent when administered in the small quantities usually provided in nutritional experiments. This is an additional reason why further careful studies of the effects of large dosage of these substances would be of value. Furthermore, such knowledge might give leads to modes of action or suggest other uses of the vitamins in the treatment of disease.



## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President, Mrs. ROBERT J. COOK, New Haven*

*President-Elect, Mrs. HAROLD W. WELLINGTON, New London*

*First Vice-President, Mrs. CHARLES W. GOFF, West Hartford*

*Second Vice-President, Mrs. JAMES DOUGLAS GOLD, Bridgeport*

*Recording Secretary, Mrs. F. ERWIN TRACY, Middletown*

*Corresponding Secretary, Mrs. EDWIN R. CONNORS, Bridgeport*

*Treasurer, Mrs. FRANK DiSTASIO, New Haven*

### PRESIDENT'S MESSAGE

Mrs. JAMES DOUGLAS GOLD, *Bridgeport*

IT HAS been the destiny of the Woman's Auxiliary to be organized at a time of social change in this country. One of the changes seen upon the horizon is a change in the science and practice of medicine. The Administration proposes to force this change upon us in the form of compulsory socialized medicine. Any change that comes in this field should be on a voluntary basis, should arise from the knowledge of physicians, not politicians, and should be planned and activated by physicians who believe in free enterprise and thought, and quality competition.

This gives the Woman's Auxiliary a clear picture of one of their major objectives—the dissemination of correct information on medical subjects to the lay public. The means by which we, as physicians' wives, will be able to do this is by continual self education on the problems confronting the profession. This has been the major project of the Auxiliary these two years since organization. And because this is so, is there a single member of the Auxiliary who does not now find herself better informed and really interested in the problems of the medical profession? Would she have been *before* she joined the Auxiliary? I don't believe she would. Now she recognizes the need for every member of the Auxiliary to become acquainted with both the scientific achievements of medicine and the economic problems of medical care so that she may pass this information along to her friends and associates. In this way each member becomes a part of the vital educational program of American medicine.

In reality the Woman's Auxiliary could be described as a huge public relations committee. One of the best agents in public relations is friendliness. Friendliness is also the basis of a successful organization and good auxiliary work. Judged by this stand-

ard our Auxiliary is already a success. I have noted with great satisfaction the friendly spirit which prevails throughout every county—new friends and delightful acquaintances have been made generally, thus carrying out one of our major objectives. Every Auxiliary member who is active as an individual in civic and woman's organizations is just that much more valuable as an auxiliary member. She has countless and innumerable opportunities to give *correct* information on medical subjects and is in the effective position of being able to contradict false statements. No one doubts the importance of public opinion. What an opportunity to mold public opinion is in the hands of auxiliary members throughout the United States who number 30,000 strong!

Through experience we have found that the more meetings held in the counties, the faster the membership grows. I think two meetings a year are too few to hold the interest of the membership and create auxiliary spirit and loyalty. We must be a united group of women as well as a purposeful group. The State Auxiliary is only as strong as its component county auxiliaries. The membership has grown this year. Let's make it still larger next year. All the counties can provide both leadership and working sinews for the growing state auxiliary.

The Auxiliary showed its depth of interest in medical problems by ascertaining the stand of the candidates of all parties on socialized medicine in the last election and the members gave thoughtful attention to these facts before casting their ballot. It has been borne in upon us that in order to be good auxiliary members we must be good politicians too!

I urge you to read the JOURNAL every month—not only the Auxiliary section but all of it. You will be surprised how interesting it is and what a great

deal of information you will assimilate, thus becoming informed on many of the problems and the attitude of the profession toward them.

Remember always that to build firmly and well you must build *slowly*. Do not be impatient. Let each year mark a few more steps forward but be sure they are firm steps and in the right direction.

The experience of serving as your president has been a happy one. I count as personal gains the contacts it has been my privilege to make with the women who comprise the Auxiliary. I wish to express my appreciation and gratitude to all my officers, to the County Auxiliaries and to each of you for your loyal support.

"The common problem, yours, mine, every one's  
Is—not to fancy what were fair in life  
Provided it could be,—but, finding first  
What may be, then find how to make it fair  
Up to our means."



MRS. ROBERT JAY COOK, *President of the Auxiliary to the Connecticut State Medical Society*

Mrs. Cook is a lawyer, is a member of the Board of Trustees of the Norwich State Hospital and member of the Board of Directors of the Grace-New Haven Community Hospital and secretary of the Connecticut Child Welfare Association, Inc.

## ANNUAL MEETING

The third annual meeting of the Woman's Auxiliary to the Connecticut State Medical Society was held on April 29 at the New Haven Country Club. Registration at 12:00 o'clock and luncheon at 1:00 P. M.

Mrs. James Douglas Gold, president, introduced Dr. Cole B. Gibson, past president of the State Medical Society, who brought greetings from the Society and commended the Auxiliary on the work accomplished during the past year. He spoke briefly on "Pre-Paid Medical Care" explaining the present situation.

Dr. Creighton Barker introduced a distinguished guest, Dr. R. L. Sensenich, chairman of Trustees of the American Medical Association. Dr. Sensenich was pleased with the Auxiliary's ability to be interested in a common project. He expressed confidence that the Auxiliary would be asked to exert leadership and guidance toward promoting the development of the best medical care for the public, and suggested ways to interest our committees along these lines.

Mrs. Gold introduced the guest speaker, Dr. Joseph I. Linde, public health officer of New Haven and a member of the Tuberculosis Commission. His subject, "Spreading the Message of Health to the People," was presented by stressing several points. Interpretation to the laity on information for good health by using the mediums of the press, radio, motion pictures and pamphlets is very important. Voluntary workers play an active part and need a fine health educator to direct this service. Members of the Auxiliary can work with organized health organizations in order to learn the problems and methods of correction. Health education in the schools, and examinations by the family or school doctor are most valuable in promoting community health. Dr. Linde concluded by emphasizing the fact that there is power in spreading information on health problems.

Mrs. James R. Miller, program chairman, presented a sound motion picture, "Danger Point," and an American Medical Association broadcast script, "More Life For You."

After the program Mrs. Gold called the business meeting to order. Annual reports of the secretary and treasurer were read and accepted. It was voted to accept the mimeographed reports of the County presidents and chairmen of standing committees. It was voted to accept the revision of the Constitution and By-Laws as presented by the chairman of the Revisions Committee, Mrs. Newell Giles.

The appointment of the following delegates to the National Convention of the Woman's Auxiliary in Atlantic City to be held this June was approved: Mrs. James Douglas Gold, Fairfield; Mrs. Dewey Katz, Hartford; Mrs. Winfield Wight, Litchfield; Mrs. Harry Pennington, New Haven; Mrs. H. F. Archambault, New London; Mrs. William MacShepard, Windham. Alternates: Mrs. Nicholas Creaturo, Fairfield; Mrs. Paul Fisher, Hartford; Mrs. George Fox, New Haven; Mrs. Harold Wellington, New London; Mrs. David Bates, Windham; Mrs. F. Erwin Tracy, Middlesex.

Mrs. Gold expressed her thanks to the officers and committees for their cooperation and gave her message as president, which appears in this issue of the JOURNAL.

The report of the nominating committee was read and accepted and the following officers were elected for 1947-1948: President, Mrs. Robert J. Cook, New Haven; President-Elect, Mrs. Harold W. Wellington, New London; Fir



Vice-President, Mrs. Charles W. Goff, West Hartford; Second Vice-President, Mrs. James Douglas Gold, Bridgeport; Recording Secretary, Mrs. F. Erwin Tracy, Middletown; Corresponding Secretary, Mrs. Edwin R. Connors, Bridgeport; Treasurer, Mrs. Frank DiStasio, New Haven.

Mrs. Gold introduced the president, Mrs. Cook, who spoke briefly on the honor of being elected and plans for the coming year.

Following a reception for the new officers, the members attended the dinner of the Connecticut State Medical Society at the Lawn Club and were delighted to again hear the dinner speaker Dr. Sensenich.

### FAIRFIELD COUNTY

The annual meeting of the Auxiliary was held April 21 at the Housatonic Lodge, Stratford. The reports of the officers and standing committees were heard and accepted. Mrs. Harold Amos, president, introduced Mrs. James Douglas Gold who brought greetings from the State Auxiliary. Mrs. Paul Brown read a message from Dr. J. Grady Booe, president of the County Medical Society.

Mrs. Edwin F. Trautman introduced the guest speaker, Mrs. Ruth Kenzie, director of rehabilitation and occupational therapy at Laurel Heights Sanatorium, who gave an interesting talk on this subject. Aid to help carry on this work as a County Project was proposed and accepted.

Mrs. Allen Ross presented the slate of officers and the following members were elected: President, Mrs. Oliver Stringfield, Stamford; President-Elect, Mrs. J. Grady Booe, Bridgeport; Vice-President, Mrs. Chester Haberman, Stratford; Recording Secretary, Mrs. Paul Brown, Stamford; Corresponding Secretary, Mrs. David McGourty, Stamford; Treasurer, Mrs. Frank Turchick, Bridgeport.

Mrs. Stringfield thanked the Auxiliary and spoke briefly on the project which had just been accepted.

### HARTFORD COUNTY

The annual meeting of the Woman's Auxiliary to the Hartford County Medical Association was held April 1 at the Hartford Golf Club, Hartford. The following new officers were elected: President, Mrs. Paul W. Tisher; President-Elect, Mrs. Ralph T. Ogden; First Vice-President, Mrs. J. Whitfield Larrabee; Second Vice-President, Mrs. Louis Gold; Corresponding Secretary, Mrs. Harvey B. Goddard; Recording Secretary, Mrs. Edwin C. Higgins; Treasurer, Mrs. James R. Cullen.

After dinner Mrs. James Douglas Gold, president of the Auxiliary, spoke briefly. The guest speaker, Mrs. Owen T. Rumsey of New Britain, chose as her subject "The Modern Woman—Is She Worth Her Keep?" Mrs. Rumsey gave some interesting excerpts from her new book which is to be published by Bobbs-Merrill Company. The members present enjoyed the interesting comparisons between the modern woman and her predecessors.

Mrs. Nicholas A. Marinaro, Newington, has designed the pin to be presented yearly to the outgoing president of the Woman's Auxiliary to the Hartford County Medical Association.

### LITCHFIELD COUNTY

Litchfield County Auxiliary held its annual spring meeting at the summer residence of Mrs. F. L. Polito, president, at Highland Lake on April 15. Mrs. W. Bradford Walker, chairman of the nominating committee presented the new slate of officers and the following members were elected: President, Mrs. Winfield E. Wight, Thomaston; President-Elect, Mrs. Royal Myers, Watertown; Vice-President, Mrs. F. L. Polito, Torrington; Secretary, Mrs. Frank Ursone, Norfolk; Treasurer, Mrs. Donald W. Herman, Winsted.

The guest speaker was Dr. Grace Mooney, executive assistant of the State Medical Society, who talked on the objectives of organized medicine and its correlation with the Woman's Auxiliary. Mrs. James Douglas Gold, State president, gave a short talk on the highlights of the accomplishments of the Auxiliary.

### MIDDLESEX COUNTY

The annual meeting was held at the Edgewood Country Club, April 24, luncheon at 1:00 P. M. A business meeting followed with the reports of officers and standing committees. The nominating committee presented the slate of officers and the following members were elected: President, Mrs. E. C. Yerbury; President-Elect, Mrs. F. Erwin Tracy; Secretary, Mrs. H. C. Knight; Treasurer, Mrs. Stanley Alexander.

The guest speaker was Mrs. Paul S. Phelps, past president of Hartford County Auxiliary whose subject was "What Hartford County Is Doing." A musical program followed.

### NEW HAVEN COUNTY

The annual meeting of the New Haven County Woman's Auxiliary was held March 26 at the Oakdale Tavern in Wallingford, with fifty-seven members present. The guest of honor, Mrs. James Douglas Gold, brought greetings from the State Auxiliary. Miss Virginia Parsons of the National Tuberculosis Association spoke on new methods of health education. The president, Mrs. Creighton Barker, reported for the various committees.

Mrs. Barnett Freedman presented the slate as chairman of the nominating committee. The new officers are as follows: President, Mrs. Harry Pennington, Meriden; President-Elect, Mrs. Arthur Morse, New Haven; Vice-President, Mrs. Lewis Foster, New Haven; Corresponding Secretary, Mrs. George Fox, Meriden; Recording Secretary, Mrs. Paul Vestal, New Haven.

### NEW LONDON COUNTY

The annual meeting of the New London County Auxiliary was held at Edgemere Manor, Stonington, April 9, with forty-eight members present. Guests of honor were Mrs. James Douglas Gold, State president; Mrs. Creighton Barker, past president of New Haven County; and Dr. Creighton Barker, secretary of the State Medical Society.

The guest speaker, Dr. Morris Fishbein, editor-in-chief of the *Journal of the American Medical Association*, was delightfully introduced by Dr. Barker. Dr. Fishbein, a dynamic speaker, was both entertaining and serious about medical economics.

Mrs. Walter Lukoski, chairman of the nominating committee, presented the slate of officers and the following members were elected: President, Mrs. C. Tyson Hewes; President-Elect, Mrs. Julian G. Ely; Vice-President, Mrs. Willard J. Morse; Secretary, Mrs. Frederick B. Hartman; Treasurer, Mrs. Harold A. Bugandahl.

Mrs. Julian Ely, chairman of the program committee, with Mrs. Eric Blank and Mrs. George H. Gildersleeve were in charge of arrangements.

### WINDHAM COUNTY

The annual meeting of the Woman's Auxiliary to the Windham County Medical Association was held at the Nathan Hale Hotel in Willimantic on April 17. After lunch Mrs. Andrew Laakso of Danielson, president of the Auxiliary, presided at a brief business meeting. Reports were read and accepted from the various officers and committee chairmen. The new officers elected were: President, Mrs. Morton Arnold, Windham; Vice-President, Mrs. William Shepard, Putnam; Secretary, Mrs. Edward Ottenheimer, Windham; Treasurer, Mrs. Karl Phillips, Putnam.

Mrs. Gardner Russell was a guest of the Auxiliary.

We were fortunate in having Dr. R. H. Guthrie of the Norwich State Hospital as our guest speaker. He gave a very interesting and instructive talk on "Psychiatric Trends of the Present Day." There are eight thousand mental patients in Connecticut mental hospitals at present and we can expect that number to double at least in fifty years. Dr. Guthrie stated that forty per cent of the general patients in a medical practice are emotional problems. The State mental hospitals have a four-point program: 1. Care and treatment of the patient; 2. Training of personnel; 3. Research; 4. Prevention of mental disorders.

The hospitals are in need of more funds. The cost per capita of the mental patients in State hospitals is now \$12.50 per week.

Mrs. James Douglas Gold and Mrs. Gardner Russell were guests of honor.

### RHODE ISLAND AUXILIARY

The Woman's Auxiliary to the Rhode Island Medical Society held its first convention at the Providence Plantation Club on May 5. Mrs. James R. Miller of Hartford attended as the guest of the Rhode Island Auxiliary. Speakers included Herman C. Pitts, M.D., president of the Rhode Island Medical Society, John E. Farrell, executive secretary of the Society, and Mrs. David Allman, first vice-president and chairman of Organization of the Woman's Auxiliary to the American Medical Association.

The following officers were elected: Mrs. Herbert E. Harris, president; Mrs. Guy W. Wells, vice-president; Mrs. Charles L. Farrell, secretary; Mrs. Jesse P. Eddy, 3rd, treasurer. The Board of Directors will comprise Mesdames H. Lorenzo Emidy, Henry J. Hanley, Arcadie Giura, Alfred Tartaglino, Thomas Nestor, Stanley Davies and Thomas J. Dolan.

Attendance at this first convention totaled 138. The new Auxiliary boasts 170 members.

## Opportunity for Tropical Disease Research

American medical students have had so little opportunity for the study of tropical medicine that Pearl Harbor found this country with only twenty-four civilian doctors with background training in this field, according to Dr. Thomas T. Mackie, with the Bowman Gray School of Medicine, and president of the American Foundation for Tropical Medicine.

Pointing out that over 50 per cent of the world's population lives in the tropical areas of the globe, subject to many little understood diseases and parasites, Dr. Mackie urged extensive study in this field. At the same time he announced the completion of an agreement between the Foundation and the Government of Liberia for the establishment of a new research center for the study of tropical disease, agriculture and animal husbandry.

The three, he says are inescapably linked for the medical problems of the tropics evolve from (1) ineffective agriculture with its poor crop yields, (2) the prevalence of highly endemic diseases of domestic animals, which together make for almost universal malnutrition; and (3) uncontrolled human diseases which lead to high infant mortality and high adult morbidity. The economic possibilities of the tropics, he pointed out, can never be realized either as an abundant source of raw materials, or as a market for manufactured products, until the health situation is corrected.

To encourage the study of tropical medicine and to stimulate research into new methods of treatment and control, the facilities of the new \$250,000 Liberian Institute will be open to students and scientists of all lands without distinction as to color, race or creed. Its research findings will also be available to all who are interested.

### Army Medical Library Consultants

Surgeon General Norman T. Kirk has appointed as honorary consultants to the Army Medical Library Major General Paul R. Hawley, USA (Retired), medical director of the Veterans Administration; Michael E. DeBakey, M.D., associate professor of surgery at Tulane University Medical School; Colonel Albert G. Love, MC-USA (Retired), formerly assistant Surgeon General; and Elliott C. Cutler, M.D., Mosley professor of surgery, Harvard University Medical School.



OBITUARIES

John Francis McHugh  
1877 - 1946

John F. McHugh was born in Woburn, Massachusetts, February 28, 1877. He attended school there before moving to Natick, Massachusetts, and graduated from Natick High School. He was a graduate of Boston College and received an M.D. from Harvard Medical School in 1901. He interned at Boston City Hospital on surgical service for a year, following which he opened an office in Wellfleet, Massachusetts, and practiced there and at Hyannis, Massachusetts, for a few years. He also served as coroner. He took another internship at Mercy Hospital, Springfield, Massachusetts, in the year 1903. After a short residency in a sanitarium in Windham, Connecticut, he opened an office in 1904 in Thompsonville and practiced there until his death.

His work consisted of a large general practice in an industrial community where he built a reputation as a leading doctor of the community. He served as industrial physician for the Bigelow-Sanford Carpet Co., Inc., from 1906 until 1921, succeeding Dr. George T. Finch.

In 1916 Dr. McHugh married Miss Julia Mun-  
kittrick, a graduate of Mercy Hospital Nursing School. Dr. and Mrs. McHugh travelled extensively in Europe, the Holy Lands and Near East in 1921 and again in 1932. Mrs. McHugh died in 1933.

Dr. McHugh was a member of the Harvard Club of Connecticut, the Connecticut State Medical Society, the Massachusetts Medical Society, and the American Medical Association. He was an active member of the Knights of Columbus and the Holy Name Society of St. Patrick's Church, Thompsonville.

His main interest, outside of medicine, was the Board of Education of Enfield, on which he served from 1934 to the time of his death in 1946. He served several terms as chairman. He was also a member of the Town Democratic Committee. He was examining physician for several fraternal organizations and the local Draft Board in World War I. He took a great interest in the stock exchange.

Dr. McHugh died at Mercy Hospital March 9, 1946 of a pancreatic tumor. The funeral was held March 12, 1946 with services at St. Patrick's Church, Thompsonville, and burial in Natick, Massachusetts. All the physicians of the community were honorary bearers. Dr. McHugh leaves one brother, Charles F. and one sister, Winifred of Thompsonville, formerly of Natick.

Bernard S. Dignam, M.D.

Ralph Edward Costanzo, M.D.  
1886 - 1946

Dr. Ralph E. Costanzo died December 26, 1946 at the Stamford Hospital while on leave from United States Army Medical Corps. He was born in New Haven August 29, 1886 received his primary and secondary education in the public schools in New Haven, and also attended Yale University. He was graduated from Loyola University Medical College, Chicago, Illinois, in 1914, and interned at New York Polyclinic Hospital 1914 to 1916.

He entered the service of his country in World War I as a lieutenant, August 8, 1917. He went overseas September 1917, was stationed at Old Mill Military Hospital, Aberdeen, Scotland, and served with the British Expeditionary Forces in France, assigned to 148th (R.N.) Field Ambulance, Drake Battalion and Hood Battalion. He was promoted to Captain, U. S. Army, while with B.E.F. February 1918. After the armistice he attended lectures, clinics, and other medical conferences at London hospitals while on Fellowships of Medicine. He returned to the United States June 1919.

Dr. Costanzo practised medicine from 1920 to 1941 in Greenwich and Stamford. He was on the staffs at Stamford, St. Joseph, and Greenwich Hospitals, and was a member of the Stamford Medical Society, the Fairfield County Medical Association, and the American Medical Association.

He was called to active duty from Medical Corps Reserve April 15, 1941 and was stationed at Fort Terry, N. Y., as Post Surgeon, was promoted to the rank of major November 29, 1941 and was assigned as Commanding Officer and Surgeon, Long Island

Harbor Defenses, Fort H. G. Wright, New York, January 1944.

He is survived by his wife Stella, two sons, Ralph Edward, age 19 years, and Donn Julian, age 15 years, two brothers, Dr. James J. and Henry A. Costanzo, and two sisters, Mrs. Frank Piazza and Mrs. James Gentile.

Lindo P. DiFrancesco, M.D.

## The Magic-Wand Theory of Medical Advance

(*The Rockefeller Foundation, A Review for 1946*)

The increasing availability of money for research in medicine is beginning to embarrass our medical schools. Where is the trained personnel coming from to make use of these funds? The general public has contributed enthusiastically to such special causes as infantile paralysis, cancer, heart disease and tuberculosis. Recently, through the National Institute of Health and the scientific branches of the armed forces, the Federal Government allocated over \$6,000,000 for similar specialized projects.

But from what source are we to get the scientists and technicians competent to work in these fields? Their training is a matter of years of preparation and it cannot be extemporized.

There seems to be a widespread public belief in what might be called the magic-wand theory of medical advance. This theory has been stimulated by the dramatic development in recent years of such remedies as insulin, penicillin, the sulfa drugs and the blood substitutes. According to this theory, our research laboratories stand ready at any time to turn money into scientific discoveries; in other words, the bottleneck to further advance is the lack of funds; with adequate funds we can buy a cure for cancer or infantile paralysis or any other disease which afflicts mankind.

The bottleneck, of course, is not the lack of funds; it is the lack of capable and thoroughly trained investigators to use the funds. The medical schools, to which we must look for these investigators, do not possess and cannot now obtain the fundamental facilities through which alone this increasing demand can be met. Indeed, many of our medical schools are in the position of a cook asked to prepare a wedding feast for which the champagne has been furnished but no water to boil the potatoes.

A survey of American medical schools indicates beyond question that what is urgently needed is not money earmarked for projects, but free funds for the training of physicians. The imposing endowments of former years dwindled during the days of panic and depression; interest rates have been cut; and sources of replenishment have been dried up by heavy taxation or by curtailment of legislative grants. The increased cost of living is tempting—indeed in some cases, is forcing—the teachers of medicine to abandon their work in the medical schools and to take up private practice.

There are in the United States today 70 medical schools offering full four-year courses in medicine. Twenty-four of these receive their major support from state legislatures, and three more are aided by less substantial sums provided by city governments. All the rest are maintained solely by tuition fees, endowment income and gifts. Even the tax-supported school depend upon private sources for important parts of their programs.

The total budgets of these 70 schools approximate \$25,000,000. With this money they must not only produce the doctors we need, but they must carry on most of the country's research into the cause and cure of disease. One of our most famous medical schools has recently reviewed its budget and has decided that even without expanding into new fields—merely to meet reasonably well the responsibilities it is already carrying—it must spend about double its present appropriation.

Our medical schools desperately need money—but not for projects. They need it for salaries, for basic plant facilities, for clinical services. It is popularly supposed that the foundations can carry the financial responsibility for medical education, but nothing could be further from the truth. The total sum available from foundations for medical education and research is only about \$3,000,000 to \$4,000,000 annually, and much of it—far too much of it—is restricted to special diseases.

This is not the place for a discussion of further government subvention of education; that subject is certain to receive an active hearing elsewhere. But in so far as our medical schools rely on private support—and many of the best of them do—that support should be intelligent and discriminating. We cannot build research without the foundations of trained personnel. We cannot grow orchids in a greenhouse that lacks coal.



SPECIAL NOTICES

CONGRESS ON OBSTETRICS AND GYNECOLOGY

The third American Congress on Obstetrics and Gynecology, September 8-12, 1947 in St. Louis has scheduled three panel-type morning sessions on the following subjects:

(1) *Anesthesia and Analgesia*, Tuesday, September 9, Nicholas J. Eastman, chairman, with the cooperation of J. P. Greenhill, Chicago; John Adriani, New Orleans; Stuart Cullen, Iowa City; and Arthur Baptisti, Hagerstown.

(2) *Cancer*, Wednesday, September 10, Robert A. Kimbrough, Philadelphia, chairman, with the cooperation of John Randall, Iowa City; Charles L. Martin, Dallas; Joe V. Meigs, Boston; and Herbert Schmitz, Chicago.

(3) *Cesarian Section* on Thursday, September 11, Edward Schumann, Philadelphia, chairman, with the cooperation of Edward G. Waters, Jersey City; Edward Davis, Chicago; E. D. Plass, Iowa City; and William Benbow Thompson, Hollywood.

The afternoon meetings of the Medical Section of the Congress will consider the Psychosomatic Aspects of Pregnancy on Tuesday; Pregnancy Complicated by Heart Disease, Diabetes and Tuberculosis on Wednesday; and Recent Advances in Endocrinology on Thursday.

Round table discussions from 4:00 to 5:00 P. M. daily will consider such topics as abortions, asphyxia, fibroids, prolonged labor, infertility, early ambulation, uterine bleeding, nutrition in pregnancy, endometriosis, the Rh factor, erythroblastosis, geriatric gynecology, and other pathologic conditions relating to obstetrics and gynecology.

Concurrent round table sessions will be held for nurses, hospital administrators and public health workers.

A Scientific and Educational Exhibit under the direction of Dr. J. P. Pratt of Detroit and a comprehensive Motion Picture Program under the guidance of Dr. John Parks of Washington are in process of development. Those wishing to make applications for space in these exhibits, especially for time on the cinema program, are urged to make early application. Necessary blanks may be obtained from the office of the Congress, 24 West Ohio Street, Chicago 10, Illinois. Better hurry!

On Friday, the last day of the Congress, the entire morning will be given over to the program of the National Federation of Obstetric-Gynecologic Societies. Dr. James S. Taylor of Altoona is arranging this session.

AMERICAN HEART ASSOCIATION MEETS

The Annual Meeting of the American Heart Association will be held at the Hotel President, Atlantic City, New Jersey, on June 6-8, prior to the Annual Session of the

American Medical Association. Members of the medical profession and other interested persons may attend the scientific sessions on June 6 and 7.

NORTON MEDICAL AWARD INVITES MANUSCRIPTS

W. W. Norton & Company are again offering the Norton Medical Award for book manuscripts written for the lay public by professional workers in the field of medicine. Terms of the award have been slightly altered. The publishers now set no final closing date for the submission of manuscripts which may be submitted at any time, the award not being limited to any one year. The Norton Award offers \$5,000 as a guaranteed advance against royalties. Either complete manuscripts or detailed table of contents together with one hundred pages of manuscript may be submitted. A descriptive folder giving full details of the terms of the award may be secured on request from the publishers, W. W. Norton & Co., Inc., 101 Fifth Avenue, New York 3, N. Y.

Books that have previously won Norton Medical Awards are *The Doctor's Job* by Carl Binger, M.D., *Doctors East, Doctors West* by Edward H. Hume, M.D., and *A Surgeon's Domain* by Bertram M. Bernheim, M.D., published this spring.



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## OUR NEIGHBORS

### Massachusetts

The Committee on Public Relations of the Massachusetts Medical Society says it is not yet ready to report on the subject of a woman's auxiliary to the Massachusetts Medical Society. A canvass of each district is to be made by the Committee member from that district and the results reported to the Committee.

### New Jersey

The New Jersey Obstetrical and Gynecologic Society was formed at the annual meeting of the Medical Society of New Jersey on April 23. All members of the State Society who devote a major part of their practice to this specialty were invited to become charter members.

### New York

After serving as secretary of the New York State Charities Aid Association for fifty-four years Homer Folks has retired. Early in the year he celebrated his eightieth birthday. *New York Medicine* credits Mr. Folks as being always a proponent of sound progressivism in medical affairs, thus endearing him to the medical profession. *The New York Times* characterizes him as "a leader in the modernization of the public health laws, in the humane and scientific care of the mentally ailing, in better care for children, in the whole broad field of public welfare."

#### STUDY OF RHEUMATIC HEART DISEASE

The crippling effects of rheumatic fever and rheumatic heart disease among school children, 7,000 of whom are estimated to be infected in New York City, will be the subject of a forthcoming study in the Lower East Side District by the New York University College of Medicine in cooperation with the New York City Health Department.

In an address before the annual meeting of Irvington House, which cares for approximately one-third of the city's rheumatic fever victims during the convalescent period, Henry E. Meleney, professor of preventive medicine of the New York University College of Medicine, said the study will get under full swing in the fall. It is planned for a minimum period of three years, and will have the guidance of a Medical Advisory Committee from cooperating agencies.

The project has the financial support of the New York Heart Association and the United States Public Health Service. Other cooperating agencies include: New York City Department of Education, Rheumatic Fever Council of the American Heart Association, the U. S. Children's Bureau, the New York School of Social Work, the Metropolitan Life Insurance Company, and other departments of the New York University College of Medicine.

A preliminary educational program among school physicians, nurses, principals and teachers has already been started.

The Doctors' Orchestral Society of New York, a full symphony orchestra of 55 instruments played by doctors, dentists and other persons affiliated with the medical profession, made its first postwar appearance May 16 in a benefit concert in the auditorium at Hunter College with proceeds to go to the New York University-Bellevue Medical Center Fund. Kenneth Gordon, talented young violinist, was a feature soloist.

Disbanded during wartime, the Doctors' Orchestral Society reorganized this winter under the baton of Ignace Strasfogel, formerly assistant conductor of the New York Philharmonic, with Artur Rodzinski recently guest conductor of symphony orchestras in New Orleans, Buffalo, Toronto, Washington, Chicago, Philadelphia and elsewhere. During two seasons Strasfogel was heard as conductor of the New York Philharmonic Symphony at Lewisohn Stadium.

Beginning as a small group of New York University College of Medicine doctors on the staff of Bellevue Hospital who formed an informal group of stringed instruments, the society grew spontaneously until in 1939 its first performance as a full symphony was given in Town Hall. Concerts at Town Hall were also given in 1940 and 1941, after which the war caused the orchestra's disbandment.

## News from Yale University School of Medicine

Arthur J. Geiger and Harold C. Anderson are the authors of a case report of "Lutembacher's Syndrome Complicated by Acute Bacterial Endocarditis" published in the February 1947 issue of the *American Heart Journal*.



## NEWS

### *from County Associations*

#### Fairfield

Lionel M. Heiden has joined the medical staff of the Veterans Administration subregional office in Bridgeport thus making a total of three full time physicians at that office. Dr. Heiden, who obtained his M.A. degree at Columbia University, was graduated from the Long Island College of Medicine in 1934, and interned for two years in Kings County Hospital, Brooklyn. After six years of general practice in New York City he enlisted in the Army and served nearly four years, two and one half of which were in England and France. He received his discharge in April with the rank of major.

Alfred G. Siege has been appointed resident physician in charge of the medical, surgical, prenatal and pediatric clinics at the Bridgeport dispensary. Dr. Siege is a graduate of New York University and New York College of Medicine and attended Duke Medical School. While in the Army he served as commanding officer of a hospital train unit. He succeeds Leonard C. Veneruso who designed recently.

Howard D. Moore, a practitioner in Danbury for half a century, died at his home in that city on March 29. Dr. Moore was obliged to retire from active practice in 1942 because of ill health.

The following physicians were recently elected members of the Stamford Medical Society: Meyer Abrahams, Howard Felding, Hugh Miller, John Ogilvie, Roy Robison, Geoffrey Snavelly.

#### Hartford

Levi B. Cochran, for over fifty years a practitioner in Hartford, died at the Hartford Hospital on April 22. For many years Dr. Cochran was a visiting physician on the staff of the Hartford Hospital, a member of his local, county and state medical societies, and a consultant to the Institute of Living.

Crit Pharris, assistant medical director of the United Aircraft Corporation, was one of the guest speakers at the 136th annual meeting of the Rhode Island Medical Society held in Providence May 14 and 15. His subject was "Trends in Part-time Industrial Health Service."

William E. Wilson has been appointed resident physician at Bristol Hospital. Dr. Wilson is a graduate of New York University College of Medicine and served an internship at Bellevue Hospital, New York City.

#### Middlesex

Since the last issue of the JOURNAL we have been recuperating from our Centennial Celebration. Considerable comment has arisen since the inclusion of our activities in Pepys' Diary.

Fred Sweet has returned from—you can easily tell where—with a beautiful coat of tan and looking in the best of health. He apparently had considerable more luck fishing than he did on his last hunting and fishing trip to the north woods.

Norman Gardner continues to be a globe trotter attending to his duties as chairman of the Committee on Rural Medicine. His most recent sortie being to Boston to address the New England Medical Council.

Our monthly Tumor Clinic is getting to be quite a well rounded program. Good followup and diagnostic attendance is taking place. We have had many visitors from throughout the State. We have outgrown our former cramped quarters and now meet in the Auxiliary Gauze Cottage. Following the Clinic we have been having very instructive discussions on clinical, pathological, and roentgenological aspects of selected groups of tumors. The Spencer Delineascope is showing its worth at every meeting.

The Wednesday morning Staff Clinics have taken on new life under the capable chairmanship of Christie McLeod. Each Wednesday finds an increasing number of the staff present and those who do not attend are really missing good medical discussions.

The Central Medical Association has finally found that rare individual who really enjoys a job. Willard Buckley as treasurer is pouncing upon various members of the Society with unholy glee. According to last reports he had better go about well protected.

Your county editor attended a meeting of the Editorial Staff following the annual Society meetings in New Haven and was delightfully entertained. It was truly an enjoyable evening and it was informative to meet other members of the staff. He is looking forward to the coming meetings.

Richard Grant has been notified of his appointment to Committee on Public Policy and Legislation of the State Society.

Benjamin Simon, M.D., of the Connecticut State Hospital at Middletown is the author of "The Place of Physical Medicine in the Treatment of Patients with Mental Conditions," published in the *New York State Journal of Medicine*, April 15, 1947.

Norman H. Gardner of East Hampton recently addressed the conference of New England State Medical Societies at the Harvard Club in Boston on the subject, "State Rural Health Programs."

### New Haven

Clarence E. Skinner, formerly a specialist in physical therapy in New Haven, died suddenly on April 24 at his home in Darien where he has lived since his retirement in 1933. Dr. Skinner practiced in New Haven until 1914 when he moved to New York to become medical examiner for several insurance companies.

Allan J. Ryan of Meriden has been appointed assistant medical examiner for the Meriden district. He will assist Dr. H. DeForest Lockwood, for many years medical examiner in the Meriden district. Dr. Ryan was born in New York, coming to this state when he entered Yale University as a student, graduating from the college and medical school. He was resident physician at the Long Island City Hospital and served as resident surgeon at the New Haven Hospital until going to Meriden. His father is Lorne M. Ryan, a retired physician living in Madison.

James L. Moriarty, a practising physician in Waterbury for many years, died in Milford early in April. He was an intimate friend of Sir Harry Lauder and prominent as an amateur actor.

The newly organized Waterbury Geriatrics Association has adopted a constitution and by-laws and elected an executive and a literary committee. On the executive committee are H. J. Stettbacher, O. J. Bizzozero, J. H. Dillon, C. H. Neuswanger, and Jacob Gancher. The literary committee comprises O. J. Bizzozero, A. F. Sullivan and S. I. Zonn.

Elbridge W. Pierce, president emeritus of the Meriden Hospital, died at his home in Meriden on April 4 at the age of 84. Following his retirement as president of the hospital five years ago, Dr. Pierce maintained an active interest in its affairs.

Edward B. Lehman, practicing radiologist in New Haven for the past ten years, died at Grace Hospital on March 30 after a short illness.

John H. Garlock of New York gave a very instructive talk at the Waterbury Medical Society on

surgery of the esophagus on May 8. The paper was discussed by Drs. Lindskog and Taffel of New Haven. There was a record attendance at the meeting.

A series of lectures on the basic sciences have been held weekly at the Waterbury Hospital for interns, residents and others interested. Most of the speakers have been members of Yale Medical School faculty.

### Tolland

At the Annual Meeting of the Tolland County Medical Association held at the Olde Homstead Inn, Somers, on April 15, the following officers were elected: John E. Flaherty, president; John Hanley, vice-president; Francis H. Burke, secretary-treasurer; Charles T. LaMoure, councilor; Ralph B. Thayer, Alfred Schiavetti, Roy C. Ferguson, censors; Wendelin Luckner, state delegate.

The speakers of the evening were Drs. Otto G. Wiedman and Charles A. Stevenson. The subject was "Diagnosis and Treatment of Convulsive Disorders." Dr. Wiedman's talk was highly instructive and thought provoking. Dr. Stevenson's illustrated talk on "Electro-encephalography" aroused much interest and a brisk question and answer period was thoroughly enjoyed by the society members.

The application for membership of S. D. Firestone, Rockville, was acted on favorably. Dr. Firestone is a transfer member from the New York State Medical Society.

### Windham

Returning home from the Windham County Association meeting on April 17, Morton H. Chapnick sustained several fractured ribs when his automobile collided with a tractor-trailer in Hampton. Dr. Chapnick's car was extensively damaged.

The 156th annual meeting of the Windham County Medical Association was held at Willimantic, April 17. The newly elected officers were Moses Margolick of Putnam, president; Reuben Rothblatt of Willimantic, vice-president; Brae Rafferty of Willimantic, clerk; Karl T. Phillips of Putnam, councilor. The speaker was John F. Fulton, M.D., professor of physiology at Yale Medical School, on "Leukotomy." Three new members, Conrad S. Baker and William S. Maurer, both of Willimantic, and Marion Whalen of Storrs, were elected to membership.



## Mental Health Organization Grants

An expanded program of public education on the problems and needs of mental patients will be undertaken by the National Mental Health Foundation through grants of \$25,000 each from Carnegie Corporation of New York and the Rockefeller Foundation. Harold Barton, executive secretary of the non profit mental health organization announced recently.

Additional grants of \$25,000 each have been promised the National Mental Health Foundation in 1948 from the Carnegie and Rockefeller funds, provided the Foundation can raise \$122,000 through popular subscription, Mr. Barton said. To seek the additional funds, the Foundation is launching a membership drive in Philadelphia and planning popular appeals throughout the country in the coming months.

Started in April 1944 by a group of young volunteer attendants in a Pennsylvania state mental hospital, the Foundation has a three-point program: (1) to inform the public on the need for more progressive and humane treatment of mental cases; (2) to secure adequate mental health facilities in every state; and (3) to encourage better training for attendants in mental hospitals.

Stressing the vital need for the Foundation's work, Owen J. Roberts, retired associate justice of the United States Supreme Court and president of the Foundation's Board of Directors, said:

"Although more than half of all hospital beds in the country are occupied by mental patients, until recently there has been little public concern for the 600,000 persons now in mental institutions, nor has there been an effective program for nation-wide public education on the nature of mental disorders. The National Mental Health Foundation is committed to just such a program which requires the cooperation of all segments of our community life."

Fostering more citizen participation in community and state mental health organizations and programs and securing more volunteer service in mental institutions will be important features of the Foundation's expanded program, according to Mr. Barton. The Foundation also publishes pamphlets and training material for mental hospital personnel and also produces radio programs designed to create a wider understanding of mental health problems, he said.

## NEW BOOKS IN REVIEW

*A BLIND HOG'S ACORNS. Vignettes of the Maladies of Workers.* By Carey P. McCord, M.D. Chicago, New York: Cloud, Inc. 1945. 311 pp. with illustrations by Strobel. \$2.75.

Reviewed by C. F. YEAGER

For those who would prefer facts regarding modern preventive industrial medicine with entertainment, they should by all means read, "A Blind Hog's Acorns," by Dr. Carey P. McCord. This book has all the thrills of a detective story. Although the book is written in a fictional style, all the experiences related are true, even the strictly scientific phases are amazingly interesting to both physicians and the general public.

Dr. McCord solves many of the baffling medical problems in industry. He has popularized this highly technical subject to an unusual degree and has written his book with exceptional literary charm.

*UTEROTUBAL INSUFFLATION.* By I. C. Rubin, M.D., F.A.C.S., Clinical Professor of Gynecology, College of Physicians and Surgeons, Columbia University; Consulting Gynecologist, Mount Sinai Hospital; Visiting Gynecologist, Montefiore Hospital; Consulting Gynecologist, Beth Israel Hospital, New York. St. Louis: C. V. Mosby Co. 1947. 453 pp. with 159 illustrations, including 4 in color. \$10.

Reviewed by STANLEY B. WELD

If the reader is looking for the technique of uterotubal insufflation it may be found covering thirty-three pages in the middle of the volume. The first section of the book is devoted to a detailed discussion of the anatomy, physiology and pathology of the fallopian tube. The chapter on physiology is long and includes detailed observations of the action of each portion of the tube, checked by experiments on the extirpated uterus and tubes as well as observations on the living. It presents in a concise form the results of years of work by many other investigators as well as the author.

The entire problem of sterility is so involved that to discuss only the factor of tubal occlusion is to limit the reader's viewpoint. Hence, it is important that the student, in particular, realizes the immense scope of the problem as a whole. If this is done, Dr. Rubin's excellent chapters on the causes of tubal occlusion and the therapeutic aspects of tubal insufflation will assume their proper balance.

The final third of the volume is given over to a discussion of the relative merits of insufflation versus injection of oils, to their relative complications and sequelae and to modifications of his own apparatus introduced by others. He even includes a discussion of the treatment of dysmenorrhea with insufflation and the use of pneumoperitoneum in gynecology.

An example of the author's thoroughness in presenting the subject is found at the end of the volume where there is

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tabulated the results of a questionnaire distributed to over 3,000 physicians. 655 replies were received of which 356 only were suitable for tabulation purposes. Connecticut is represented by E. A. Herr, J. H. Howard, J. R. Miller, and L. K. Musselman.

The author has added to the value of this volume by supplying a generous number of illustrations, all of sufficient size and clarity to be readily interpreted. He repeatedly emphasizes the value of the kymograph in performing tubal insufflations and the ability to localize the point of obstruction with his apparatus, obviating the need for the injection of any kind of opaque media followed by roentgenography.

Dr. Rubin is the leading expert in the field of uterotubal insufflation. He presents in book form the results of his years of experience, his observations of the work of others in this field, and answers to many of the queries he has received in the course of his travels.

**STRUCTURE AND FUNCTION OF THE HUMAN BODY.** By *Ralph N. Baillif*, PH.D., Associate Professor of Anatomy, Louisiana State University School of Medicine, New Orleans; and *Donald L. Kimmel*, PH.D., Associate Professor of Anatomy, Temple University School of Medicine, Philadelphia. Philadelphia: J. B. Lippincott Company. 1945. 328 pp. with 158 illustrations. \$3.00.

Reviewed by L. A. CHOTKOWSKI

In this text an attempt is made to correlate, as the title infers, the structure and function of the human body. This is done incompletely as one would expect in view of the tremendous scope of such an undertaking. The material is

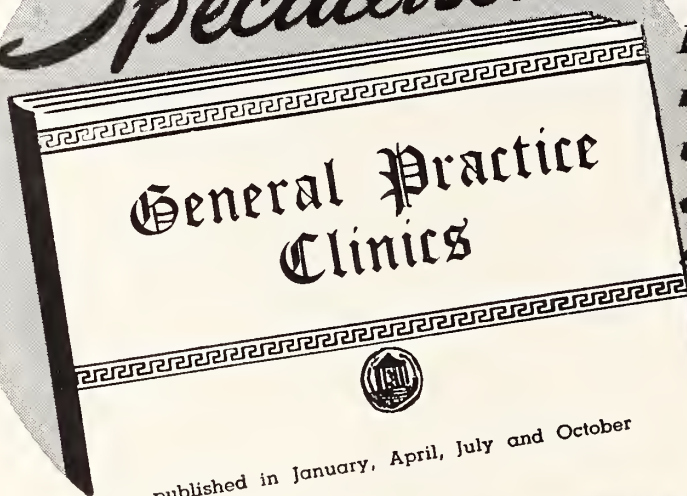
presented in a well organized although somewhat didactic and almost outline form. Because of this it would seem that a pre-existing knowledge of anatomy and physiology would be requisite to its proper understanding. Although it is written for the student primarily, on the other hand, it might offer the practitioner a fruitful change from current, every day, purely clinical literature.

**PRINCIPLES AND PRACTICE OF OBSTETRICS.** (Ninth Edition.) By *Joseph B. DeLee*, M.D., late Professor of Obstetrics and Gynecology, the University of Chicago; Consultant in Obstetrics, the Chicago Lying-in-Hospital and Dispensary; and *J. P. Greenhill*, M.D., Attending Obstetrician and Gynecologist, the Michael Reese Hospital; Obstetrician and Gynecologist, Associate Staff, the Chicago Lying-in Hospital; Chairman Department of Gynecology, Cook County Hospital; Professor of Gynecology, Cook County Graduate School of Medicine. Philadelphia and London: W. B. Saunders Company. 1947. 1011 pp. 1,108 illustrations on 860 figures, 211 in color. \$10.

Reviewed by STANLEY B. WELD

Four years ago Dr. Greenhill published DeLee's Principles and Practice of Obstetrics with many additions and changes, most of which were approved by the senior author before his death. The present edition comes entirely from the pen of Dr. Greenhill but lacks none of the completeness and painstaking care evidenced in previous editions. The format of this ninth edition follows that being adopted by many publishers today, a two-column page which at the same time with narrower margins carries more words to a page and is

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been added and the entire procedure of caudal analgesia discussed. The chapter on "Ectopic Pregnancy" has been rewritten and brought up to date. Many new infectious diseases accidental to pregnancy have been included and new material on diseases of the blood added. New material is to be found in the chapters on "Endocrine Disorders," and "Local Diseases Accidental to Pregnancy."

The new chapter on "Fetal Erythroblastosis" is excellent but already the treatment of the same is progressing too rapidly for a textbook. There is an excellent new chapter included on "Care of Premature Babies" and another on "Circumcision."

In place of a former short section on "Minor Disturbances in Pregnancy" this edition affords an entire chapter on the subject. It leaves much to be desired since the number of minor disturbances is almost legion. The use of douches in late pregnancy impress the reviewer as too unsafe, especially when there are available today preparations with the proper pH which will clear up the majority of vaginal infections.

The discussion of methods of postpartum care is so ultra conservative as to seem almost outmoded in some of its details. This is one field in which the exigencies of war have necessitated the abandonment of many practices formerly believed necessary.

In the discussion of the use of penicillin in breast abscess no mention is made of aspiration of pus when necessary and of the injection of penicillin into the surrounding cellulitis.

This textbook will continue to be an authority frequently consulted by specialist and general practitioner. The increase in the number of illustrations, so many in color, adds to the value of the volume.

read more easily. The list of references at the end of each chapter has been augmented to include the original reference for every name mentioned in the entire textbook.

As the author informs us in the preface, new chapters have been added, some have been omitted, others combined and all rewritten with new material added. Particular attention should be directed to the newly written chapter on "Physiology of the Fetus" and to the excellent discussion of premarital examination, pre-pregnancy examination, a careful history and complete physical examination of the pregnant woman in the rewritten chapter on "Antepartum Care." In the chapter on "Diagnosis of Pregnancy," a discussion of basal body temperature has been added, and in the chapter on "Analgesia and Anesthesia" demerol and divinyl ether have



**GYNECOLOGICAL AND OBSTETRICAL PATHOLOGY WITH CLINICAL AND ENDOCRINE RELATIONS.** (Second Edition.) By *Emil Novak, A.B., M.D., D.Sc. (Hon. Dublin), F.A.C.S.,* Associate in Gynecology, Johns Hopkins Medical School; Gynecologist, Bon Secours and St. Agnes Hospitals, Baltimore; Fellow, American Gynecological Society, American Association Obstetricians, Gynecologists and Abdominal Surgeons nad Southern Surgical Association; Honorary Fellow, Societe Francaise de Gynecologie; Royal Institute of Medicine, Budapest; Sociedad d'Obstetricia et Ginecologia de Buenos Aires; Central Association of Obstetricians and Gynecologists; Texas State Association Obstetrics and Gynecology; Past Chairman, Section on Gynecology and Obstetrics, A.M.A. *Philadelphia and London: W. B. Saunders Company. 1947.* 542 illustrations, 15 in color. 570 pp. \$7.50.

Reviewed by **STANLEY B. WELD**

Seven years ago Emil Novak published the first edition of Gynecological and Obstetrical Pathology. Delayed by the shortage of labor and paper the second edition has just appeared. As stated in the review of the first edition, this volume continues to be one of the most valuable of its kind published. The second edition follows the pattern of the first, with a discussion of the opinions of other leading authorities in the field of obstetrics and gynecology and, when in disagreement, the reasons for the author's views.

The chapter on Abnormalities and Diseases of the Placenta and Appendages contributed by L. M. Hellman is included as in the former edition, but there is added to it new material on aging of the placenta and on erythroblastosis. Additional information is included on the blood supply of the endometrium and on the vagina. In the discussion of the histology of the cervix a short paragraph is included on decidual changes found in the cervix. Dr. Novak cautions against the error of too hasty diagnosis of malignancy of the cervix in doubtful cases. The contribution of vaginal smears stained by the Papanicalaou method to the diagnosis of uterine cancer is discussed.

There is considerable new material on the endometrium. We have already mentioned the discussion of the blood supply. In the chapter on the histology of this part of the uterus the new knowledge of its secretory activity is recorded, its vascular behavior, and the postmenopausal and senile changes taking place. In the discussion of hyperplasia of the endometrium the author's opinion as to the predisposing role of postmenopausal hyperplasia in the development of adenocarcinoma is worthy of note. Also of interest is the newer concept of stromal adenomyosis of the uterus and the rarity, mixed mesodermal tumors of the corpus uteri.

The section on the ovary offers a new discussion of mesonephroma of the ovary and another on adenocarcinoma with clear cells. The page on the effects of granulosa cell

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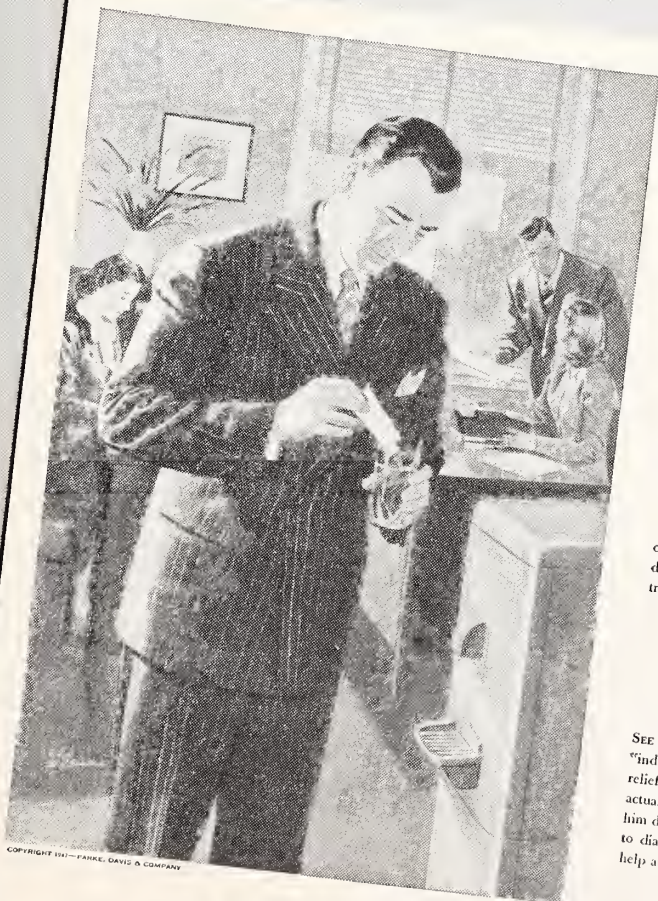


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tumors and thecomas of the endometrium is new and epoch making. New material has been added to the paragraphs on preliminary maturation changes in sex cells.

As in the first edition, this one contains almost as many illustrations as pages, and the addition of the colored cuts makes this edition more attractive as well as valuable. The references at the end of each chapter again afford the student a working list of the more worthwhile contributions bearing on the various subjects. The publishers have kept the price at the same figure as in the former edition, a welcome surprise in this day of rising costs.

*AN INTEGRATED PRACTICE OF MEDICINE—A Complete General Practice of Medicine from Differential Diagnosis by Presenting Symptoms to Specific Management of the Patient.* By Harold Thomas Hyman, M.D., Volumes I, II, III, and IV, and Index. Philadelphia and London: W. B. Saunders Company, 1947. 1184 illustrations, 305 in color. 319 Differential Diagnostic Tables. \$50 per set.

Reviewed by RALPH E. DURKEE, JR.

This is a compact set of four volumes containing a tremendous amount of up-to-date information on general medicine. The stated purpose of the author is to provide a comprehensive source of reference for the general practitioner and there can be no question but that this goal has been achieved admirably. The small print and narrow margins made necessary during the war permit the condensation of an amazing amount of material into these handy-sized books. The tables of differential diagnosis of common symptoms and signs form a useful addition to the usual system of medicine and aside from their value for reference, they will train the practitioner to approach each diagnostic problem with a broad perspective.

Volume I contains sections on General Reactions of Body Tissues, Infection, Allergy, Neoplasms, Metabolism, Poisoning and The Circulatory System. The section on general reactions is quite brief and might well be omitted from such a reference work. The section on neoplasms consists of a few general remarks contained in ten pages. The sections on infection and the circulatory system are especially good and there are numerous excellent colored photographs throughout the volume.

Volume II contains sections on The Blood and Blood Forming Organs, Organs of Internal Secretion, The Nervous System, The Eye and the Digestive System. The author's figures of 120-150 mg per cent for normal fasting blood sugar and the necessity for glucose tolerance tests on all cases of fasting blood sugar under 200 mg per cent will be questioned by many. The section on the eye is compact but comprehensive and should be useful to the general practitioner in deciding which cases to treat and which to refer.

Volume III contains sections on The Respiratory, Urinary and Reproductive Systems, Obstetrics, Pediatrics and The Skeletal and Locomotor Systems.

Volume IV contains sections on The Tegumentary System, Physical Diagnosis, Laboratory Methods, Therapeutics, Pharmacotherapy, Major and Minor Surgery, Prognosis, and Appendix. Although the discussion of skin conditions is good and there are many excellent photographs, it would seem that a disproportionately large amount of space has been

devoted to this section. The appendix is interesting in that it contains a chapter of advice regarding the establishment of an office practice and a very comprehensive table of occupational hazards and their diagnostic features.

In general the information set forth is accurate and when the opinion of the author is inserted, it almost always agrees with the prevailing medical opinion of today. This is not a set of books for the specialist in internal medicine; he will invariably want more detail about each subject. Acute coronary occlusion is dealt with in fourteen pages and peptic ulcer in seventeen. One does not find discussions of such recent developments as the use of B A L in arsenic and mercury poisoning or the use of anticoagulants in acute coronary thrombosis. By making a treatise so all-inclusive one must necessarily sacrifice detail in the discussion of any one subject. This does not detract from the value of the work, however; it is rather a necessary feature in order that the stated purpose of providing a comprehensive reference for the general practitioner be fulfilled.

*THE YEARBOOK OF PSYCHOANALYSIS.* Volume 2. Sandor Lorand, M.D., Managing Editor. New York: International Universities Press. 1946. 280 pp. \$7.50.

Reviewed by C. C. BURLINGAME

The second volume of the Yearbook of Psychoanalysis features what the editors consider the most outstanding psychoanalytic contributions to appear in the literature of 1945. The fourteen papers thus reported emanate from a variety of British and American sources, including journals in the field and individual monographs published during that period. This is a particularly well chosen group, broad in coverage, with timely emphases for current problems of clinical and social psychiatry. The subjects range from the genetic approach in psychoanalysis and problems of classification, analysis and therapy itself, to Freud's translated essay on Dostoevsky and various social problems appertaining to crime and punishment, moral issues in psychoanalysis and in man's psychology, and the possible applications of psychoanalytic formulations to problems of war and peace.

Of particular interest to the reviewer was Fenichel's paper entitled "Nature and Classification of the So-Called Psychosomatic Phenomena," which provides a logical differentiation between conversion states, organic diseases of psychogenic origin, and organ-neurosis, with subdivisions of this last group in terms of affect equivalents, hormonal changes resulting from unconscious affects, physical results of unconscious attitudes, and combinations of all these mechanisms. The necessity for a combined physical, chemical and psychodynamic approach to psychosomatic medicine is well pointed up in this article, one of the last of Fenichel's many contributions to psychoanalytic theory. Another contribution of major importance is that of Kubie and Margolin relating to "The Therapeutic Role of Drugs in the Process of Repression, Dissociation and Synthesis." This appeared originally in the journal *Psychosomatic Medicine* and is of more than esoteric interest in view of the current vogue of narcotherapies.

For individuals and libraries having no ready access to the psychoanalytic literature, this yearbook serves a useful purpose, reproducing the cream of the published work in this field for a year's period and furnishing a more comprehensive reading list at the close of the volume.



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# *The* CONNECTICUT STATE MEDICAL JOURNAL

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## THE ABDOMINOTHORACIC APPROACH FOR HIGH GASTRIC NEOPLASMS A Preliminary Report

R. STARR LAMPSON, M.D., R. H. OSMOND, M.D., and N. W. WAWRO, M.D., *Hartford*

THE HORIZONS of the surgeon have broadened with the progress of anesthesia, the advent of antibiotics and the clinical application of fundamental physiology in the preparation and convalescence of the surgical patient. The surgical pioneers of fifty years ago conceived and executed radical procedures which are only now becoming established as reasonable operations. This is nicely illustrated in the discussion of high gastric carcinoma by Robson and Moynihan<sup>1</sup> in their monograph "Surgical Treatment of Diseases of the Stomach" which was published in 1901. Reference is made to Mikulicz "who removed a primary carcinoma of the cardia and a portion of the esophagus between three and four centimetres in length." Unfortunately the patient died of peritonitis but Mikulicz expressed the hope "that even carcinoma of the lower end of the esophagus might prove within the safe reach of a capable surgeon."

The diaphragm long stood as a barrier against the upward advance of the abdominal surgeon and it was the thoracic surgeon who transgressed this muscular boundary from above to enter the abdomen and carry out combined thoracico-abdominal resections of the esophagus and the stomach.<sup>2</sup> As the attack against neoplasms of the upper stomach developed, some advanced the concept that an abdominal approach should first be made to determine the operability of the lesion and to execute the preliminary steps of freeing the stomach so that it could be readily delivered into the chest at a second stage which was carried out from above through the left thorax.<sup>3</sup> If the tumor was inoperable, thoracotomy would be unnecessary. Others maintained that there

was no need for an abdominal approach when the stomach is so accessible from above and advocated a single procedure through the chest and diaphragm for exploration and resection in the favorable cases.<sup>2</sup> The ease and safeness of exploratory thoracotomy have made the transthoracic approach an accepted and well recognized procedure for high gastric lesions.

Within the past few months the abdominothoracic approach to high gastric tumors has been presented separately by Humphreys<sup>4</sup> and Garlock.<sup>5</sup> This procedure has combined in a single operation the advantage of a laparotomy for abdominal exploration to evaluate the extent of the disease and the wide exposure of a thoracotomy for lesions adjacent to the diaphragm. If radical excision is impossible the chest is not opened and a minor palliative procedure such as gastrostomy may or may not be done depending upon the circumstances. The technique described by these authors is quite similar and embodies an upper abdominal incision which can be extended upward across the costal margin and into the chest through the eighth interspace. The diaphragm is then incised downward to the esophageal hiatus so that an excellent exposure for the radical resection of high gastric and low esophageal lesions is obtained (Figure 1).

On the surgical service at the Hartford Hospital the abdominothoracic approach has been done in three patients with high gastric carcinoma. The incision has proved very satisfactory and the immediate results are gratifying. This preliminary report presents a brief experience with this approach and gives a short case summary for each patient.

*From the Surgical Service of the Hartford Hospital*

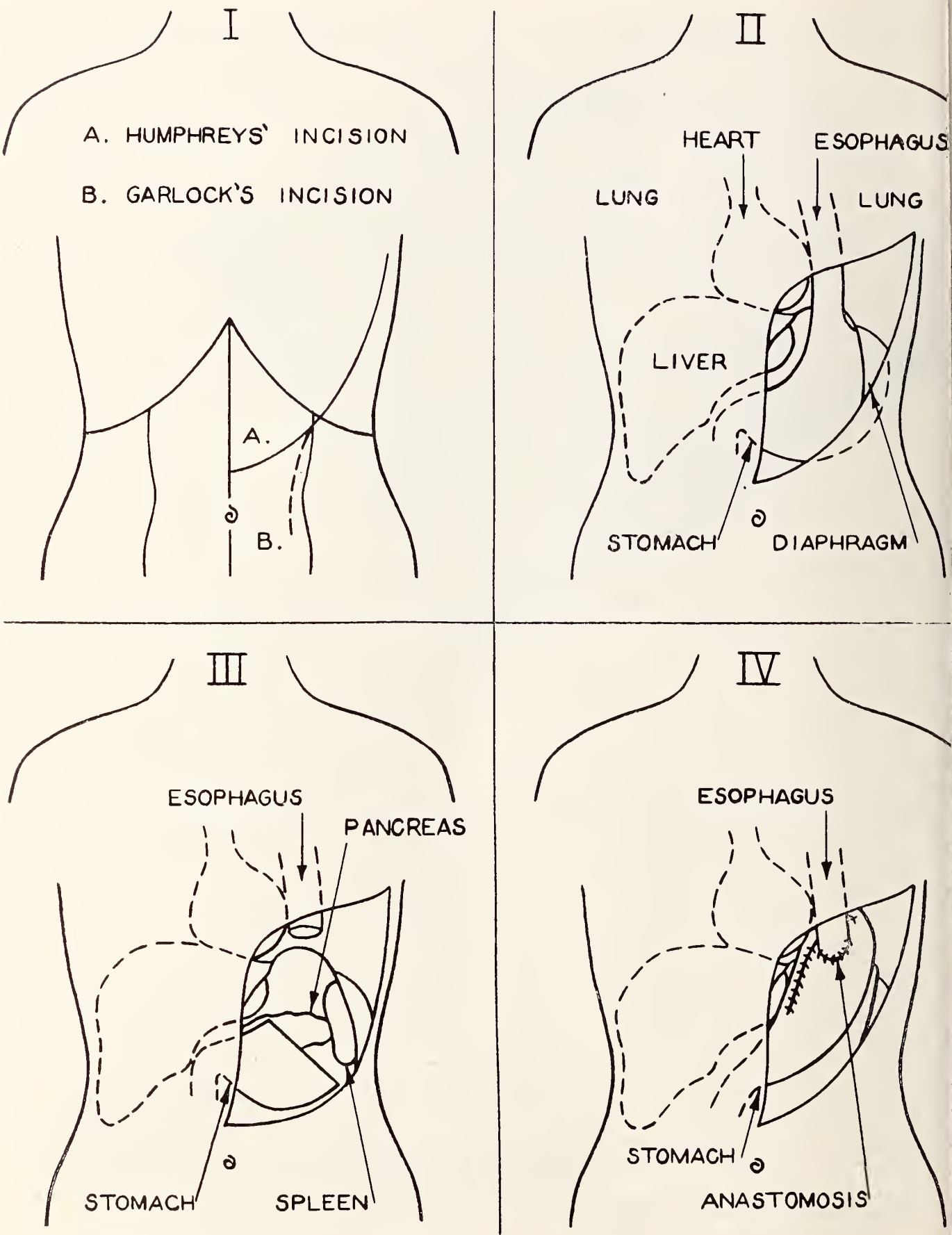


FIGURE I - DIAGRAM OF IMPORTANT OPERATIVE STEPS



## CASE I—NO. 554-384

Mrs. C. R. a 56 year old white woman was admitted to the Hartford Hospital on December 5, 1946 with a six months history of mild epigastric pain which radiated up under the sternum and down to the umbilicus. This pain was accompanied by difficulty in swallowing and some regurgitation after eating. The patient had lost twenty-five pounds in weight. Six weeks before entry, gastro-intestinal x-rays showed an extensive lesion involving the cardia of the stomach. (Figure II.) The patient was urged to go to the hospital for surgery.

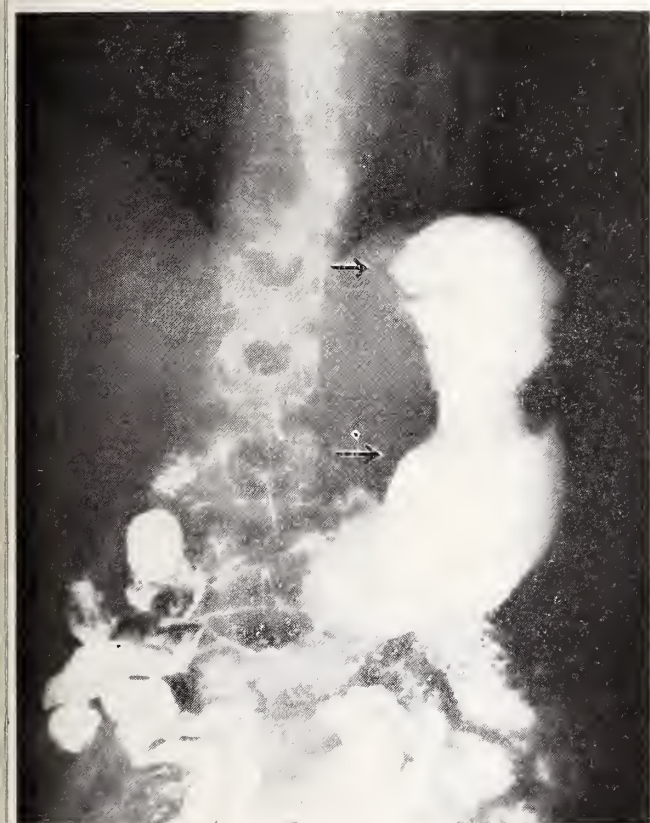


FIGURE II

Case No. I—Preoperative x-ray showing tumor of the upper one half of the stomach

On admission, examination revealed a thin, dehydrated, frail, pale woman who looked older than her stated age. The chest was clear, the heart was slightly enlarged, blood pressure 160/100, rate 100. There was a loud, harsh systolic murmur at the apex. Abdominal examination showed the liver to be down two inches below the costal margin. An indefinite mass was felt to the left of the mid-line in the epigastrium. The laboratory findings before operation disclosed that the urine was normal, hemoglobin 64 per cent, hematocrit 35, white blood count 7,400, non-protein nitrogen 23, serum protein 5.3. Electrocardiogram showed right axis deviation. Three transfusions were given and on December 16, 1946 exploration was done.

Under endotracheal inhalation anesthesia an upper left rectus incision was made and an extensive but resectable malignancy of the upper one half of the stomach was found. The incision was extended across the costal margin and into the eighth interspace. The diaphragm was opened down to

the esophageal hiatus. The spleen, the proximal two-thirds of the stomach and the lower esophagus were resected. A careful gastro-esophageal anastomosis was done and the diaphragm, chest and abdomen closed in layers with intercostal drainage through the ninth interspace.

The pathological report was returned "adenocarcinoma of the stomach with metastases to regional lymph nodes. Normal spleen. Normal biopsy of liver." The postoperative course was complicated by atelectasis but a satisfactory convalescence followed and she was discharged on the twenty-third postoperative day able to eat a light but adequate diet.

## CASE II—NO. 558-343

Mrs. A. C. a 38 year old white woman was admitted to the Hartford Hospital on January 25, 1947. She was well until three months before admission when the onset of progressive dysphagia occurred. This was accompanied by a sensation of sticking at the lower angle of the sternum. There was loss of appetite, strength and twenty pounds of weight. At the time of admission the patient could swallow liquids and very soft foods, but not solids. Physical examination was not remarkable. The heart and lungs were normal. Blood pressure 150/95. Pulse regular.

Gastro-intestinal series before entry showed a neoplasm at the cardia of the stomach with possible involvement of the lower esophagus. (Figure III.) Esophagoscopy indicated that the tumor involved the cardiac end of the esophagus. The essential laboratory findings before operation were: Urine specific gravity 1.026, albumin 0, sugar plus, white blood cells plus, red blood cells 0; hemoglobin 60 per cent; hematocrit 33.5; white blood count 8,850; serum protein 5.5.

Under endotracheal inhalation anesthesia operation was done through a transverse left upper quadrant incision which



FIGURE III

Case No. II—Preoperative x-ray showing tumor at the cardia and lower esophagus



was extended across the costal margin into the eighth interspace when the operability of the large high gastric tumor had been established. The diaphragm was opened to the esophageal hiatus. Resection of the lower six centimeters of the esophagus, upper one half of the stomach, omentum, spleen, and tail of the pancreas was done. A gastro-esophageal anastomosis was completed and the diaphragm, chest and abdomen closed in layers, with intercostal drainage through the ninth interspace.

The pathological report was returned "adenocarcinoma of the stomach, Grade II, with metastases to regional lymph nodes. Normal spleen and tail of pancreas." After a satisfactory postoperative reaction the patient made a good recovery and left the hospital on the twenty-fourth hospital day able to eat a six meal bland diet. Postoperative gastro-intestinal series showed a good functioning stoma and prompt emptying through the pylorus.

#### CASE III—NO. 553-985

Mrs. P. G. a 62 year old housewife first entered the Hartford Hospital on December 1, 1946 because of epigastric pain for six to eight months which was not related to meals.



FIGURE IV

Case No. III—Preoperative x-ray showing tumor of the upper one-third of the stomach

Nausea without vomiting was noted. During this time there was a weight loss of eighty pounds. For one month the patient had been passing black, tarry, foul-smelling stools. On the morning of admission she developed acute swelling and tenderness of the left leg which was attributed to thrombophlebitis. The past history disclosed hypertension for five years with recent exertional dyspnea for which digitalis was prescribed. Examination revealed marked pallor. The heart showed enlargement to the anterior axillary line, an aortic systolic murmur and auricular fibrillation. Blood pressure

140/85, rate 96. The lungs were clear. Abdominal examination showed evidence of recent weight loss but no masses were felt. There was swelling and tenderness of the left leg. Laboratory findings were: Urine specific gravity 1.015, albumin two plus, sugar 0, white blood cells three per cent; hemoglobin 50 per cent; hematocrit 20.5; red blood count 2,800,000; white blood count 6,500; non protein nitrogen 80; serum protein 6.6. Electrocardiogram showed auricular fibrillation and left ventricular strain. Gastro-intestinal x-ray showed a tumor of the cardia of the stomach. (Figure IV) After three weeks in the hospital the patient improved with blood transfusions and rest. Operation was advised but she refused and went home.

On February 15, 1947 she re-entered the hospital because her previous symptoms had become more severe and she was anxious to obtain relief through surgery. On February 24, 1947 after supportive preoperative preparation including blood transfusions, exploration was done.

Under endotracheal inhalation anesthesia a left upper abdominal transverse rectus incision was made and a large but movable tumor of the cardia was found. The incision was extended across the costal margin into the eighth interspace. The upper one half of the stomach and the lower five centimeters of the esophagus were resected and a gastro-esophageal anastomosis done. The wound was closed and an intercostal catheter was placed through the ninth interspace into the chest.

The pathological report was returned "adenocarcinoma Grade II, of the stomach with metastases to regional lymph nodes." The postoperative course was smooth. The patient was taking small amounts of liquids on the second day after



FIGURE V

Case No. III—Postoperative x-ray shows the remaining distal portion of the stomach and the esophageal anastomosis above the diaphragm



was out of bed on the ninth postoperative day and able to eat a soft diet. Postoperative examination showed satisfactory filling and emptying of the stomach. (Figure V.) She was discharged improved on the twenty-seventh day after operation.

#### DISCUSSION

Resection of the upper stomach and lower esophagus is a formidable procedure by any route and under the most favorable circumstances carries an appreciable mortality. Expert anesthesia, the general use of whole blood transfusions, and special nursing attention following operation are essential for good results. Each of these patients received inhalation anesthesia administered endotracheally. Cyclopropane, nitrous oxide and minimal quantities of ether were employed. Carbon dioxide absorption was utilized and on appropriate occasions controlled respiration was maintained. Curare was used as an adjuvant to produce maximal degrees of muscular relaxation. At least four transfusions of citrated whole blood were given to each patient during the operation. A special nurse was in constant attendance for the first three days after operation in each case. In order to encircle the disease, it may be necessary to carry the dissection down to the celiac axis, to remove the spleen and possibly some of the pancreas, in addition to resecting the involved portion of the stomach and esophagus. It should be emphasized that the anastomosis must be done with meticulous care to assure accurate mucosal approximation. To accomplish this the cut end of the stomach is inverted and a new opening three and one half centimeters in length is made to accommodate the esophagus. There must be no tension on the suture line. This is assured by adequate mobilization of the stomach, by mattress sutures to reinforce the anastomosis and by fixation to the diaphragm which is then closed around it. Pleural infection is minimized by the insertion of a number eighteen rubber catheter through the ninth interspace to provide closed drainage for several days. A strong wound is achieved by approximating the thoracic incision in layers followed by careful abdominal closure. A jejunostomy for feeding has been advocated by Garlock but was not used in these cases. Instead a Levin tube was passed into the stomach at operation to remain for twenty-four to seventy-two hours as a guard against postoperative gastric dilatation. Prophylactic suction bronchoscopy to minimize the possible development of atelectasis was done in each instance at the close of the operation.

The postoperative management requires adequate

parenteral fluids including blood, amigen and ample vitamins. Intranasal oxygen should be administered as long as it is needed. The use of penicillin is important for the prevention of sepsis in the mediastinum and the pleural space. A small intake of fluid by mouth may be started beginning on the second or third day. It should be remembered that the remaining stomach has been vagectomized and is, therefore, prone to distention. It must be promptly decompressed at the first sign of fullness. The diet is gradually increased so that by the second week the patient is receiving adequate nourishment by small but frequent feedings.

The three patients in whom this resection has been done all had extensive disease with lymph node spread. They have all been operated upon within the past five months. In view of the extensive disease, it would be difficult to anticipate brilliant long range cures in any of these three patients. It is clear, however, that so far good palliation has been accomplished. The abdominothoracic approach which has been used has proved most satisfactory. Our offensive against an inaccessible region of the gastrointestinal tract has been strengthened by this route of attack.

In making this preliminary report it is hoped that surgeons will be encouraged to use the approach in circumstances where radical resection would otherwise seem ill advised and that physicians, who might not ordinarily delve into the special surgical journals, will be aware that the assault against neoplasm of this region has advanced.

#### SUMMARY

1. The abdominothoracic approach for high gastric tumors has been discussed.
2. Three cases successfully handled by this approach have been presented.

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## THE ROLE OF SOME OF THE NEW CHEMOTHERAPEUTIC AGENTS IN THE SURGICAL TREATMENT OF HYPERTHYROIDISM

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THE PURPOSE of this paper is to discuss briefly the role of some of the newer chemotherapeutic agents, in particular thiouracil, in the surgical treatment of hyperthyroidism. As a preamble to a discussion of the subject, it seems fitting to review briefly the more important stages in the evolution of the surgery of this condition.

During the first decade of this century, when the surgery of thyrotoxicosis was in its infancy and well before the therapeutic value of Iodine was appreciated, partial thyroidectomy upon the thyrotoxic patient was attempted rarely, and then only by a handful of the leading surgeons of the day. Despite the best efforts of men of this calibre, the morbidity and mortality attendant upon operation were so high that this era has been aptly referred to as the "period of trial and error in thyroid surgery."

The next decade, which has been called "the period of multiple stage operations," saw the introduction of polar ligation, staged procedures and a more standardized surgical technique. While these and numerous other measures appreciably reduced the incidence of complications and the fatality rate following surgery, the operation continued to be attempted by a relatively small group of specialists only. Notwithstanding these circumstances, it maintained its reputation as a hazardous procedure with the profession at large.

With the publication in 1923 of the now classic work of Plummer<sup>1</sup> on the use of iodine in the control of thyrotoxicosis, the treatment of this condition was revolutionized and the "iodine era" was at hand. This was by far the greatest advance in the

control of the disease that had occurred up to that time. The preoperative preparation of the thyrotoxic patient on iodine so greatly reduced the morbidity and mortality from thyroidectomy that from being considered a hazardous procedure entrusted to an especially skilled few, it became a relative safe procedure performed by many. In a comparatively short time, iodine followed by surgery was adopted by the profession in general as the therapy of choice in the vast majority of cases of hyperthyroidism.

Shortly before World War II, the mortality rate from this operation on thyrotoxic patients in four of the larger clinics and University hospitals<sup>2,3,4</sup> in this country varied from .3 per cent to 1.25 per cent. While figures of this nature may alter from year to year and an exact interpretation is not always possible, the mean mortality rate of the four reports was 0.72 per cent. So safe had this form of therapy become, in fact, that in many of our larger institutions the training of the resident surgeon was considered incomplete if he had not performed successfully a reasonable number of these operations by himself.

In 1936, despite the success and comparative safety of the surgical treatment of hyperthyroidism Pemberton<sup>6</sup> wrote "there still remains for solution the problem involved in a small group of patients . . . who cannot be made safe surgical risks by prolonged medical management . . . Since the condition of these patients cannot be improved materially by any known measures short of partial removal of the goiter, and since the operative mortality among them is relatively high, there is obviously the need of some other therapeutic measure which will either abate the intensity of the hyperthyroidism or will fortify the patient better to endure the postoperative reactions."

*Presented at the 21st Connecticut Clinical Congress, New Haven, September 10, 1946*

*From the Department of Surgery, College of Physicians and Surgeons, Columbia University and the Surgical Service, the Presbyterian Hospital, New York*



This in essence was the status of the surgical treatment of hyperthyroidism until the publication in 1943 of Astwood's investigations<sup>7</sup> on thiourea and thiouracil. It was his epochal work, then, that ushered in the present era of chemotherapy in the treatment of thyrotoxicosis.

As will be remembered, after investigating more than 100 compounds in the thiourea and sulfonamide series, Astwood found the thiourea group to be the more effective of the two and of this series, he considered 2-thiouracil the most promising for clinical trial. Here in brief was a drug which, when administered for a sufficiently long period of time, would not only produce a complete abatement of all symptoms, but would also induce actual hypometabolism in the thyrotoxic patient, if pushed far enough. By its action the synthesis of the thyroid hormone in the body seemed to be prevented and this supposition has subsequently been borne out by other investigators. While pointing out the benefits of thiouracil in his first clinical article, Astwood reported a case of agranulocytosis due to its use and warned at the time that it might prove toxic in some patients. This, as is well known, has subsequently proved to be the drug's most important disadvantage.

Since the publication of this work, the literature on the subject has become voluminous, to say the least. Not only has thiouracil now received a most extensive clinical trial both alone and in combination with surgery, but other chemotherapeutic agents of both the thiourea and sulfonamide series have been the subject of extensive investigations both clinically and in the laboratory.

With regard to the latter, it goes without saying that it has been the constant hope of all concerned that some compound less toxic than thiouracil, but equally efficacious in controlling the hyperthyroid state, would be discovered. Thus far thiourea and propyl-thiouracil have proved the most promising of the many substances of this nature subjected to clinical trial.

Inasmuch as Dr. Danowski has just discussed thiourea in the preceding paper,<sup>8</sup> and because also our own experience with this drug is meagre indeed, it will not be taken up here. With regard to 6 propyl thiouracil or "probacil," it is the author's feeling that from the standpoint of the surgeon at least, this drug has not yet received clinical trial sufficient or extensive enough for its evaluation. It may be said at this point, however, that its clinical action appears to be similar to the thiouracil in most respects,

with the important exception that thus far "probacil" has proven much less toxic. In December 1945, Astwood<sup>9</sup> reported the use of this drug in 37 patients with no toxic reactions. In a similar, but unpublished, series of approximately the same number at the Presbyterian Hospital in New York City, we have thus far had only one questionable side reaction, an urticaria. With regard to the use of "probacil" in conjunction with surgery, as far as the author is aware, there have been no formal reports in the literature as yet. At the Columbia-Presbyterian Medical Center the series of 5 cases prepared for surgery with this drug is still far too small and too recent to merit comment, except to state that thus far its action seems identical with thiouracil in every respect save in the matter of toxicity. It may also be stated that the original initial dosage of "probacil" proposed by Astwood of 75 mg. per day has seemed insufficient in our clinic and therefore our cases are now being prepared on dosages of double this amount or 50 mg. three times daily.

The only other chemotherapeutic agents which have been tried at the Presbyterian Hospital are tetra-methyl-thiourea and para-amino-benzoic acid. As these were not used sufficiently in any of the cases coming to surgery to have had an appreciable effect in their preparation, the author is not in a position to comment on them in this respect. Drs. Aranow<sup>10</sup> and Werner,<sup>11</sup> however, who have been investigating these drugs in our thyroid clinic, report that their effects have thus far been disappointing.

As mentioned previously, of all the newer chemotherapeutic agents employed in the treatment of thyrotoxicosis, thiouracil has received by far the most extensive clinical trial and it can be safely said, I believe, that it has now been used sufficiently to pass judgment upon its place in the surgical therapy of this condition. The experience of most surgeons using this drug has been consistent and uniform. Our own has proved no exception. It has been accumulated in a series of 53 cases coming to surgery following preparation with this drug. Forty-seven of these have been reported in detail elsewhere.<sup>12</sup> In our conclusions as to the indications for its use in conjunction with surgery, we may differ slightly with some authors, but basically we are in agreement on all main points. Before going into this aspect of the problem, it seems advisable to review briefly, from the standpoint of the surgeon, the generally

accepted experience of the profession at large with this drug.

PREPARATION

The customary initial dosage of thiouracil varies from .4 gm. to .6 gm. daily, depending somewhat on the severity of the disease. The majority of our cases have received the larger initial dosage—the usual method being to give 0/2 gm. three times a day. This is continued until the basal metabolism reaches normal and the symptoms of hyperthyroidism are relieved. As the metabolism approaches zero, the dosage may be cut to a maintenance level of 0.1 or 0.2 gm. per day until the patient is ready for surgery. Two or three weeks prior to the date set for operation, it is wise to start the patient on daily doses of Iodine in the customary amounts. The iodine is maintained in conjunction with thiouracil up to the day of operation. If desired, as suggested by Lahey,<sup>13</sup> the thiouracil may be discontinued a week prior to operation, provided the metabolism has reached normal, but the iodine should be maintained. The object of giving this drug just prior to operation in conjunction with thiouracil is to cause involution of the gland and thereby minimize its vascularity and friability during the operative procedure. We shall have occasion to refer to this more fully presently.

During the preparation of the patient with thiouracil, the three most essential points to be remembered are:

1. That the patient must be watched closely for the development of possible toxic reactions to the drug.
2. That thiouracil *must* be continued long enough to insure complete relief of symptoms and an absolutely normal metabolism at the time of operation.
3. That hypometabolism due to the drug must not be allowed to occur, especially at the time surgery is undertaken.

TOXICITY

To recapitulate, point number one, concerning the toxicity of thiouracil, is surely the most important of the three. As mentioned previously, the toxic potentialities of this drug are its greatest drawback and it has been established beyond question that if it is improperly controlled, death due to agranulocytic angina may ensue.

Van Winkle and his coworkers,<sup>14</sup> reporting the toxicity of thiouracil in 5,745 cases, found the in-

cidence of granulocytopenia among the entire series to be 2.5 per cent. Of 142 cases developing this complication, 21 died, giving a mortality rate of .4 per cent for the series as a whole and a case fatality rate of 14 per cent for agranulocytosis. Furthermore, these investigators found that approximately 13 per cent of all cases treated with thiouracil could be expected to show some adverse reaction. In order of importance, the three most common complications reported by these authors were:

	PERCENT OF ALL TOXIC REACTIONS	PERCENT OF THE ENTIRE SERIES
1. granulocytopenia	19.0%	2.5%
2. leukopenia	33.0%	4.4%
3. drug fever	20.5%	2.7%

As will be seen in Table I, in which are presented toxicity figures from the first 110 cases treated with thiouracil at the Presbyterian Hospital, the overall incidence of side reactions, as well as the mortality rate in this small series were somewhat higher than those reported by Van Winkle and his associates. Apparently the severe bone marrow reactions are most frequently seen in the early weeks of treatment, the majority occurring within the first 12 weeks. It is none too reassuring to learn, however, that they may occur as late as the 56th week. The obvious lesson to be learned from this, of course, the necessity for close observation of the patient and repeated examinations of the blood, especially during early treatment. It has been the policy at the Presbyterian Hospital to see these patients and check the status of their blood and basal metabolic rate each week for the first eight weeks, then twice a month for the next few months, and at longer intervals thereafter.<sup>12</sup>

With regard to point number two, or the necessity for continuing thiouracil until an optimal effect has been obtained, there are several important considerations which merit brief discussion.

The first of these may be taken up under the heading of the duration of time necessary to obtain a response with thiouracil. This varies considerably in different individuals, but by and large it has been found that "fresh" cases respond the most rapidly. Fresh cases refer to those of comparatively short duration which have not received previous therapy, in particular previous iodination. The previous use of Iodine seems definitely to slow the response to thiouracil. It has, therefore, been recommended that in this type of case the drug be continued for from



TOXIC REACTIONS IN 110 CASES TREATED WITH THIOURACIL  
(JUNE 1943 — JANUARY 1946)

TABLE I

REACTION	NUMBER OF CASES	PERCENT OF TOXIC REACTIONS	PERCENT OF TOTAL CASES
*Agranulocytosis	5	22.6	4.5
Leukopenia or Neutropopenia	11	50.0	10.0
Fever	2	9.1	2.2
Thyroiditis	2	9.1	2.2
Parotitis	1	4.6	1.09
Skin	1	4.6	1.09
Total Reactions	22	100.0	20.0
*Death from agranulocytosis	1	4.6	1.09

60 to 100 days before considering this variety of preparation a failure. It should also be noted that toxic nodular goiter tends to respond more slowly to thiouracil than the diffuse type. It may be significant in this connection that thus far in well over 100 cases at the Presbyterian Hospital there has not been a single failure in response to thiouracil therapy except when the drug was discontinued prematurely.

Unfortunately one cannot as yet predict categorically the length of time necessary to prepare an "average" patient for surgery on thiouracil. Lahey has stated that approximately one day for each degree that the initial metabolism is elevated above normal should be allowed in estimating the time that will be required for the metabolic rate to fall to normal. It has been our experience, however, that there are too many variable factors involved to be able to rely on this formula consistently.

The second important consideration concerning the duration of treatment with thiouracil is the necessity for insuring that the drug be administered for a sufficient period of time to insure an absolutely normal metabolism at the time of operation. Of ten "untoward" postoperative reactions following preparation of patients on this drug at the Presbyterian Hospital—seven were due to inadequate anteoperative control. This finding has been consistently called attention to in the surgical literature on this subject.

With regard to the last, or third point emphasized earlier—namely the importance of avoiding the production of hypometabolism with thiouracil—it has been generally found that when the metabolism is depressed below normal by this drug, the gland

may become considerably enlarged, and very vascular. At operation this type of gland may well prove exceedingly difficult to handle, not only because of its size and vascularity, but also because of extreme friability.

# OPERATIVE FINDINGS

There is little doubt that in an appreciable number of cases prepared for surgery on thiouracil the glands are found at operation to be unusually friable and vascular. This is true irrespective of whether the metabolism is depressed below normal at the time or not. Lahey emphasizes this fact, as do Clute,<sup>15</sup> Cope<sup>16</sup> and many others who have struggled with glands of this nature. From a purely technical point of view, this is the only disadvantage of the thiouracil prepared gland versus the gland prepared on iodine. The seriousness of this objection seems to have been somewhat mitigated by the use of iodine for two to three weeks anteoperatively, as mentioned previously. This does not mean, however, that iodine used in this fashion will completely abolish this difficulty,—for unfortunately these soul-trying procedures still occur occasionally despite its administration.

The great advantage of thiouracil from the technical standpoint is the fact that most cases prepared on this drug come to operation in a practically "non toxic" condition. Hence the need for rapidity in operative technique is not so acute and the necessity for the staged procedure practically non-existent. The anesthesia problem is greatly simplified. There is usually little alteration in pulse or blood pressure throughout the procedure and last, but not least, it is a great mental and moral comfort to the operator to know that in these cases the likelihood of "storm" is remote.

# HISTOPATHOLOGY

Microscopic sections of material removed at operation reveal that the classic thiouracil response is one of extreme hyperplasia with marked loss of colloid. Figure 1 shows a resting or normal thyroid from a case of coronary sclerosis. Figure 2 shows a typical toxic diffuse gland prepared on Iodine. Figure 3 depicts the classic thiouracil response in the gland of a patient with severe primary hyperthyroidism. The difference between these three sections are obvious. It should be pointed out, however, that not all cases of toxic diffuse goiter prepared on thiouracil exhibit this extreme picture.



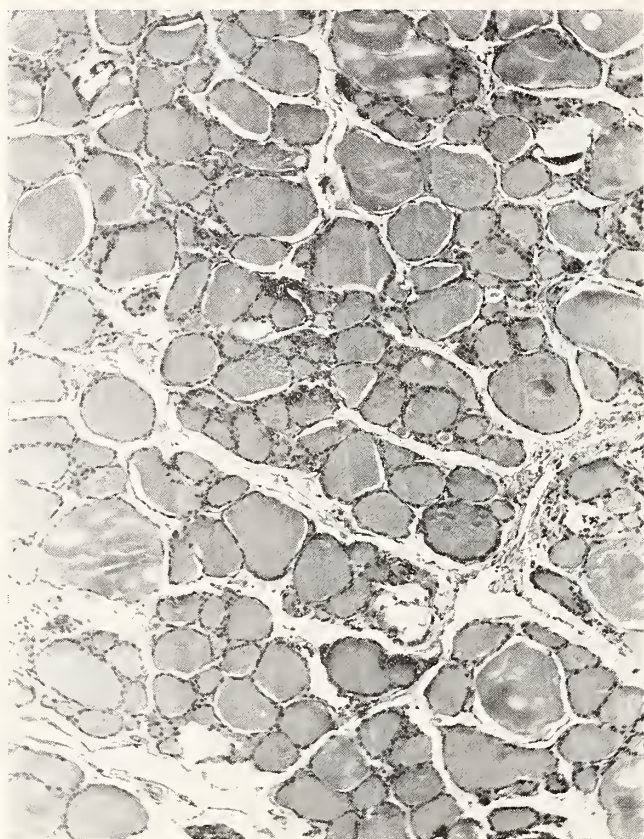


FIGURE 1

Resting or normal thyroid from a case of coronary sclerosis (Courtesy of Dr. Virginia Kneeland Frantz, Department of Surgical Pathology, Columbia University, New York, N. Y.)

in addition to thiouracil anteoperatively. The other did not. Both were definitely thyrotoxic after operation and their respective postoperative courses differed little from the average severe case prepared on Iodine alone. Because of the foregoing, it seems advisable to continue iodine for a few days after operation, although the thiouracil may be stopped.

#### FOLLOW UP

Thus far the follow up results in this group of patients compare favorably with those of patients prepared for operation on Iodine. It must be admitted, however, that it is perhaps still too soon to pass final judgment. Forty-seven of our fifty-three cases have been followed for from 6 months to just under three years. The remainder are too recent to comment upon. Of these forty-seven, there has been one persistence of the disease, and one recurrence after 18 months. The remaining patients are in good health and apparently free of their disease. In the case of persistent hyperthyroidism, insufficient gland was removed from a patient who had

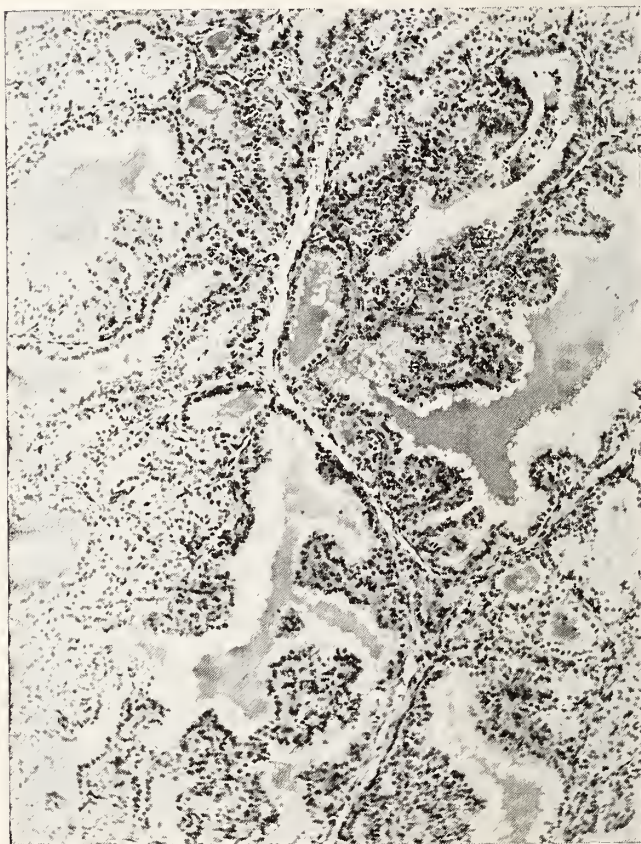


FIGURE 2

Toxic diffuse goiter after preparation for surgery on iodine (Courtesy of Dr. Virginia Kneeland Frantz, Department of Surgical Pathology, Columbia University, New York, N. Y.)

#### POSTOPERATIVE COURSE

As intimated previously, the occurrence of severe postoperative reactions in patients prepared on thiouracil is rare indeed. For the most part a smooth course can be anticipated which, while perhaps not quite as innocuous as that following the ablation of a non toxic goiter, may in many instances compare favorably with a postoperative course of this type. As a rule these patients can be allowed out of bed on the day following operation and home on the fourth or fifth day, always provided, of course, that there is no preexisting cardiac complication or other contraindication. It should be emphasized, however, that despite a seemingly adequate anteoperative course of thiouracil, an occasional case will show postoperative reactions similar to the average severely toxic patient prepared on iodine. We have had two such instances among our 53 cases prepared on this drug. Both went into operation with normal metabolisms and appeared entirely relieved of all symptoms of thyrotoxicosis. One received iodine



previously been operated upon for the same condition with Iodine as the anteoperative preparative drug. The single instance of recurrence of the disease has taken place in a patient whose goiter was extremely difficult to remove because of excessive bleeding and who, therefore, probably did not have enough gland removed. She is now being prepared for a second thyroidectomy on Iodine.

# COMMENT

Earlier in this paper Pemberton was quoted as pointing out the obvious need for some therapeutic measure other than Iodine which would "either abate the intensity of the hyperthyroidism" in the severely toxic cases "or fortify the patient better to endure the postoperative reactions." It would seem that in thiouracil such an agent is already at hand. This is not to say that there is not room for improvement or that such improvement may not be already on the way in the form of "probacil," or some other chemotherapeutic agent, for the ultimate answer lies obviously in the future.

Nor need it be inferred that thiouracil should entirely replace iodine in the preparation of the thyrotoxic patient for surgery. On the contrary, those of us who have been following this problem for the past 3 years at the Presbyterian Hospital believe that for the average thyrotoxic patient the use of iodine is still the best method of preparation. Thiouracil, we believe, should be principally reserved for the group referred to by Pemberton namely: the poor surgical risks.

In order to clarify this, and sum up our own point of view on the indications for the use of thiouracil in the surgery of thyrotoxicosis we may, therefore, say that we believe this drug should be used in:

1. The severer grades of hyperthyroidism.
2. Thyrocardiacs.
3. Those cases which are refractory to or cannot tolerate iodine.
4. Those cases in which surgery is refused or for any reason considered inadvisable.
5. A selected group of recurrent toxic goiter, and
6. Juvenile hyperthyroidism.

# SUMMARY

To summarize, then, some of the new chemotherapeutic agents give promise of fulfilling a long felt need in the surgical treatment of hyperthyroidism. This need is concerned with the better control

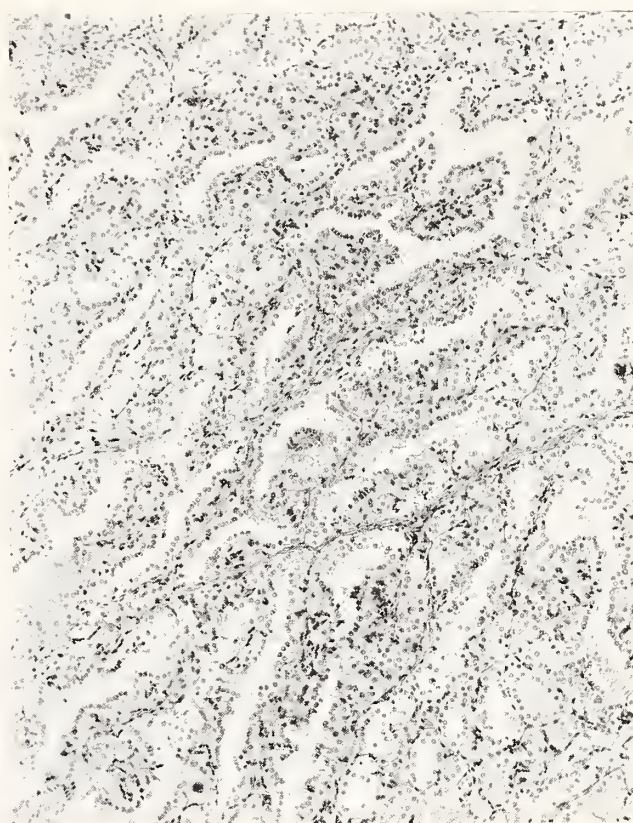


FIGURE 3  
"Classic" thiouracil response in a toxic diffuse goiter (Reproduced by permission of the Annals of Surgery, 12)

both anteoperatively and postoperatively of a group of patients severely ill of this disease.

Of the newer chemotherapeutic agents, thiouracil has definitely earned for itself a place in the surgical therapy of thyrotoxicosis by fulfilling this need. The surgeon who uses this drug, however, should be fully aware of its toxic potentialities and be prepared to guard against them.

Other agents give promise of perhaps exceeding thiouracil in usefulness. It is our sincere hope that this promise will be fulfilled.

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## CONCENTRATED HUMAN PLASMA ALBUMIN IN TREATMENT OF NEPHROTIC EDEMA

### A Report of Four Cases

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THE TREATMENT of nephrosis and the nephrotic stage of chronic glomerulo-nephritis has undergone a fundamental change in the last few decades. Whereas clinicians formerly recommended reduction of protein in the diet to 60 grams daily, Epstein advocated a high protein diet of 120 grams of protein or more, to counterbalance the great loss of protein in the urine which occurs in both conditions.<sup>1</sup>

The differential diagnosis of genuine lipoid nephrosis from the nephrotic stage of chronic glomerulo nephritis is at best difficult and often impossible, especially when the carefully taken history does not reveal a previous attack of acute nephritis. Lipoid nephrosis and the nephrotic stage of chronic glomerulo nephritis are each characterized by the following: edema, massive albuminuria, decreased plasma protein, with reduction of the albumin fraction, lipemia, hypercholesterolemia, absence of retinopathy and absence of hypertension and renal insufficiency. In both conditions doubly

refractile lipid bodies, casts and white blood cells may be found in the urine. The pathologist often finds chronic glomerulonephritis when the diagnosis of nephrosis is made by the clinicians, on the basis of repeated negative urine examinations for occult blood and the absence of a history of acute nephritis. Amyloid nephrosis can usually be differentiated from these two conditions by the absence of a chronic infection, the absence of hepatomegaly and splenomegaly, and a negative congo red test.

Despite the difficulties in the differential diagnosis between nephrosis and the nephrotic state of glomerulo nephritis, the treatment in both conditions is essentially the same. The most urgent problem is to eliminate the marked and often incapacitating edema which, in both conditions, is associated with marked proteinuria and hypo-proteinemia. The loss of albumin is thought to be more important in producing the edema than is the loss of globulin since the colloid osmotic pressure of a solution of albumin is more than three times that of globulin. This is due to the smaller albumin molecules. As a general rule, one can assume that the plasma albumin content of less than 2.5 grams per cent (normal 4 to

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grams per cent) and the total protein less than 5 grams per cent (normal 7 to 8 per cent) is associated with edema.<sup>2</sup>

Normally, fluid is forced into the tissue spaces in the arterial end of the capillaries because the hydrostatic pressure is greater than the colloid osmotic pressure at that point. At the venous end of the capillaries the hydrostatic pressure falls below the osmotic pressure and reabsorption of tissue fluid into the blood results. If at the venous end of the capillaries the osmotic pressure is markedly decreased through the loss of albumin, as is the case in nephrosis and in the nephrotic phase of chronic glomerulonephritis, the reabsorption of fluid from the tissues is disturbed, and edema results.

If the low colloid osmotic pressure which results from the loss of plasma albumin is the cause of the edema, the logical therapy should be to raise this pressure by restoring the normal level of plasma albumin. This was attempted by various means, such as whole blood transfusions, infusion of plasma, infusions of amino acids,<sup>3</sup> convalescent serum, fourfold concentrated serum gained through the lyophilic process,<sup>4</sup> and acacia solutions intravenously.<sup>5,6</sup> Each of these substances has its merits but some failures and occasional dangerous reactions were reported. The substance physiologically best fitting for restoring the normal plasma level seemed to be concentrated human plasma albumin. This has been made up for the Armed Forces in units containing 5 grams of albumin in 100 cubic centimeters of a neutral buffer fluid. 100 cubic centimeters of this solution is osmotically equivalent to 500 cubic centimeters of plasma but it has the advantage of containing less sodium chloride.

This solution was used for treatment of patients afflicted with the nephrotic syndrome. Administration of the solution was maintained at a rate not faster than 5 cc per minute in order to prevent the occurrence of pulmonary edema or untoward reaction. Massive doses of albumin were given because it was known from experience that it takes great quantities of protein to restore the plasma protein in an organism depleted of proteins. The whole body apparently acts as a common pool for protein and the protein level of the plasma rises only with the level of other protein stores in the body.

In addition to the plasma albumin, our patients received a high protein, high carbohydrate, low salt diet. Fluid was not restricted in view of the salt

restriction. Each patient also received orally 60 gm daily of Amigen, an enzymatic hydrolysate of casein which contains a mixture of polypeptides and amino acids. Some patients received 60 grams of urea in three equal doses in fruit juices.

#### CASE NO. 1—W.S.

A 21 year old negro with three and one half years army service was admitted November 1945 for observation of albuminuria which was found on routine examination. He did not offer any complaints but stated that he had albuminuria previously in 1939 and 1942 on routine health examinations. There was no history suggestive of acute nephritis in the past. Physical examination was essentially negative. His blood pressure was 120/80 mm of Hg and his normal weight of 198 pounds increased to 206 pounds with marked sacral edema and edema of the legs and face.

Laboratory examinations were as follows: Repeated urine examinations showed albumin ranging from a trace to 4+ with a few granular casts, white blood cells and red blood cells on microscopic examination. Twenty-four hour quantitative albumin determinations showed more than 3000 mg. On concentration and dilution tests, the patient was able to concentrate to 1.020 and dilute to 1.008. Blood chemistry studies revealed a blood urea nitrogen of 11 mg per cent, cholesterol of 260 mg per cent and a total plasma protein of 3.4 grams per cent with 1.7 grams per cent of albumin and 1.7 grams per cent of globulin. Routine blood studies revealed 16½ grams of hemoglobin and a white count of 5,700 with a normal differential. The electrocardiogram and fragility tests were both normal.

*Hospital Course:* The patient was treated with a high carbohydrate, high protein and low salt diet. In addition, he received 15 grams of urea and 60 grams of Amigen in grapefruit juice four times daily. This treatment failed to cause a diuresis or effect his weight in any manner. Therefore, the intravenous administration of albumin was started on December 23, 1945. At that time he received 1 unit. This was repeated on December 25 and January 1 resulting in a drop of weight from 207 pounds to 192 pounds by January 4, 1946, at which time his plasma protein had increased from 3.4 grams per cent to 4.1 grams per cent with 2.3 grams per cent of albumin and 1.8 grams per cent of globulin. His urine continued to show 4+ albumin. He received an infusion of one unit of albumin on January 6 and January 7 without any change in weight. For some unexplained reason, the protein dropped to 3.4 grams per cent by January 17 but increased to 3.8 grams per cent by January 23 with 1.9 grams per cent of albumin and 1.9 grams per cent of globulin. At this time he received a course of six infusions, each containing two units of albumin and being given on alternate days. Following this, the plasma protein remained unchanged but the weight dropped to the normal 182 pounds. He maintained this weight despite an additional infusion of two units of albumin on February 4, at which time all medications were discontinued including urea and amigen. An E.C.G. and fragility test at this time were normal. He was kept on a high protein, high carbohydrate and moderate salt diet until March 4, 1946 without any apparent change in

weight or physical condition and was discharged at that time. However, despite massive doses of albumin which had been given, his plasma protein level dropped to 3.1 grams per cent with a globulin level of 1.4 grams per cent and albumin of 1.7 grams per cent.

#### COMMENTS

This is a patient with the nephrotic stage of glomerulo nephritis, who was put on a regime of high protein, high carbohydrate and low salt diet along with 60 grams of urea and 60 grams of anigen daily without any apparent change in his status. Following the administration of three units of plasma albumin, he developed a diuresis and his weight dropped from 206 pounds to 184 pounds without any apparent change in his plasma protein level. After the infusion of albumin was discontinued his weight again increased to 192 pounds despite continuation of all other therapy. Following a course of 16 units of albumin given intravenously in two unit doses, his weight dropped to 182 pounds which was the normal weight of this individual. All other therapy except dietary was then discontinued. His plasma protein level during his entire course of therapy did not undergo any significant change to account for his diuresis and weight loss.

#### CASE NO. II—M.N.

This 21 year old negro male stated that he was entirely well until July 1945 at which time he first noticed swelling of the face and ankles. This was followed by abdominal cramps for which he went on sick call. There was no past history of scarlet fever, recurrent sore throats or any episodes of acute nephritis.

At that time the physical examination was negative except for a generalized edema. His weight was 197 pounds and his blood pressure was 112/84.

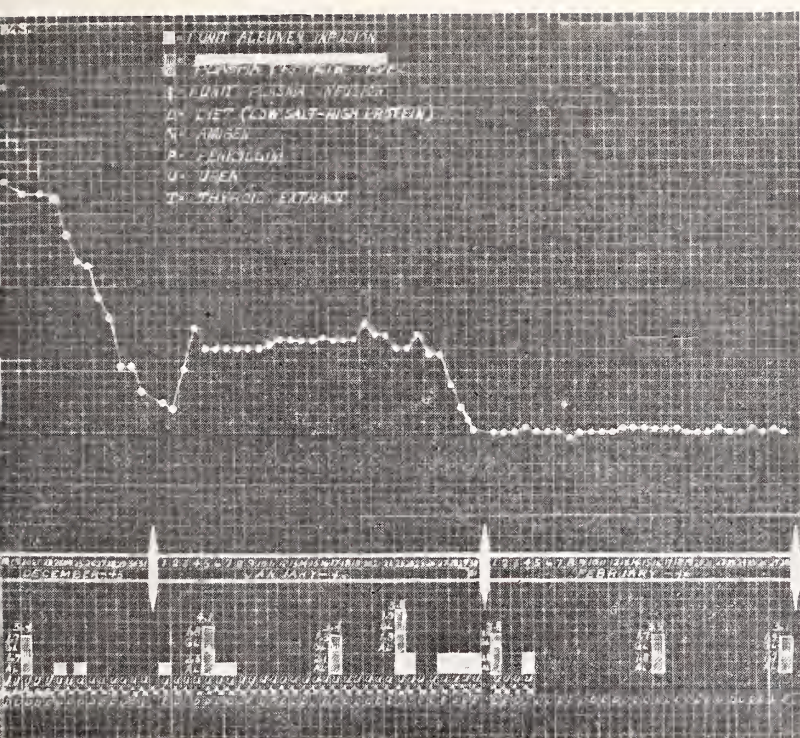
*Laboratory Findings:* Examination of the urine revealed a 4+ albumin with a quantitative determination of 1800 mg of albumin per 24 hours. Microscopically, occasional red blood cells, granular casts and white blood cells were found. The specific gravity was 1.020. The blood chemistry revealed a blood cholesterol of 381 mg per cent, urea nitrogen of 19 mg per cent and a total protein of 3.4 grams per cent with 1.7 grams per cent albumin and 1.7 grams per cent of globulin. A BMR was minus 23 per cent. X-ray of the chest and E.C.G. were negative.

*Hospital Course:* Following his admission, he was put on a high protein, high carbohydrate and low salt diet. Fluid was not restricted. In addition, he received 5 grains daily of thyroxin but the edema increased and he developed ascites. Therefore, on December 4, 1945, which was about 6 months after the onset of edema, one unit of dried plasma in double concentration (two units of plasma dissolved in 250 cc of distilled water) was administered intravenously. Following this, he developed severe chills and fever which was thought to be due to a tubing reaction. A similar course of 2 units

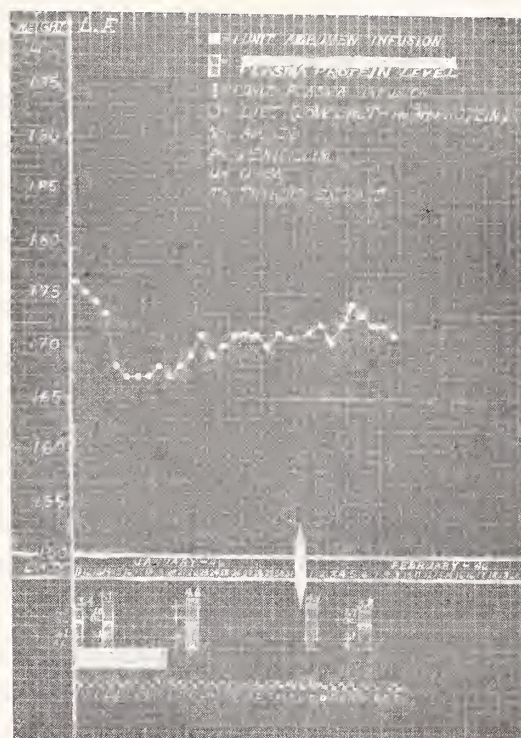
of dried plasma was given the following day with a similar reaction plus a marked urticaria. It was felt that this was probably a reaction to the plasma and that it was unsafe to continue this type of therapy. The plasma protein before the first infusion was 3.4 grams per cent with 1.7 grams per cent of albumin and 1.7 grams per cent of globulin. Following the second infusion, it had not changed substantially and remained 3.6 grams per cent total plasma protein with 2.0 grams per cent of globulin and 1.3 grams per cent of albumin. His edema and weight had not changed. He continued to complain of generalized aches and pains and developed a non productive cough several days after the infusion. Examination of the chest at that time revealed fluid in both bases with medium, moist râles in the left chest posteriorly near the upper border of the lower lobe. Examination of the abdomen revealed marked ascites. His temperatures rose to 103 degrees. The patient became very drowsy and was placed on the seriously ill list. He received 25,000 units of penicillin intramuscularly every two hours for seven days. Following this, his fever, drowsiness, and generalized aches and pains subsided.

On December 10, 1945 he received two units of concentrated human serum albumin. This was given without any apparent ill effect. After this, his weight dropped from 190 pounds to 187 pounds within 5 days. He received 6 units of albumin in divided doses over a four day period beginning December 15, 1945. 15 grams of urea and 15 grams of anigen in fruit juices were also given four times a day as an adjunct. Under this regime the patient's weight dropped from 187½ pounds to 163 pounds. The ascites disappeared, the temperature remained normal, and his lungs became clear. On December 25, 1945 the patient received another two units of albumin at which time his plasma protein had risen to 5.5 grams per cent with 2.7 grams per cent of globulin and 2.8 grams per cent of albumin. However, by January 5, 1946 this had again fallen to 4.1 grams per cent total protein, despite the continuation of urea and anigen, high protein, high carbohydrate and low salt diet. His weight and edema began to increase at this time and by January 26 he weighed 187 pounds again. His plasma protein was 3.4 grams per cent with 1.7 grams per cent of albumin and 1.7 grams per cent of globulin. Beginning January 23 two units of albumin were given daily for seven days. Following this his weight again dropped to 175 pounds and his plasma protein again rose to 5.1 grams per cent. His weight remained essentially unchanged until February 1946 when another two units of albumin were given. This was followed by mild diuresis and weight loss. At this time all therapy was discontinued except the high carbohydrate high protein, low salt diet. By February 21, the edema had increased, and his weight reached 192 pounds. The plasma protein level was 3.5 grams per cent with globulin 1.2 grams per cent and albumin 2.3 grams per cent. The patient then developed a spontaneous renal crisis. He began to lose weight continuously, and by March 13 his weight had dropped to 164 pounds without any treatment except for his high protein, high carbohydrate, low salt diet. The urine continued to show albumin up to 4+, occasional white cells and granular casts. A fragility test and E.C.G. taken at the completion of the treatment were both normal. At the present time, the patient is feeling well and has been sent on a 30 day convalescent furlough.

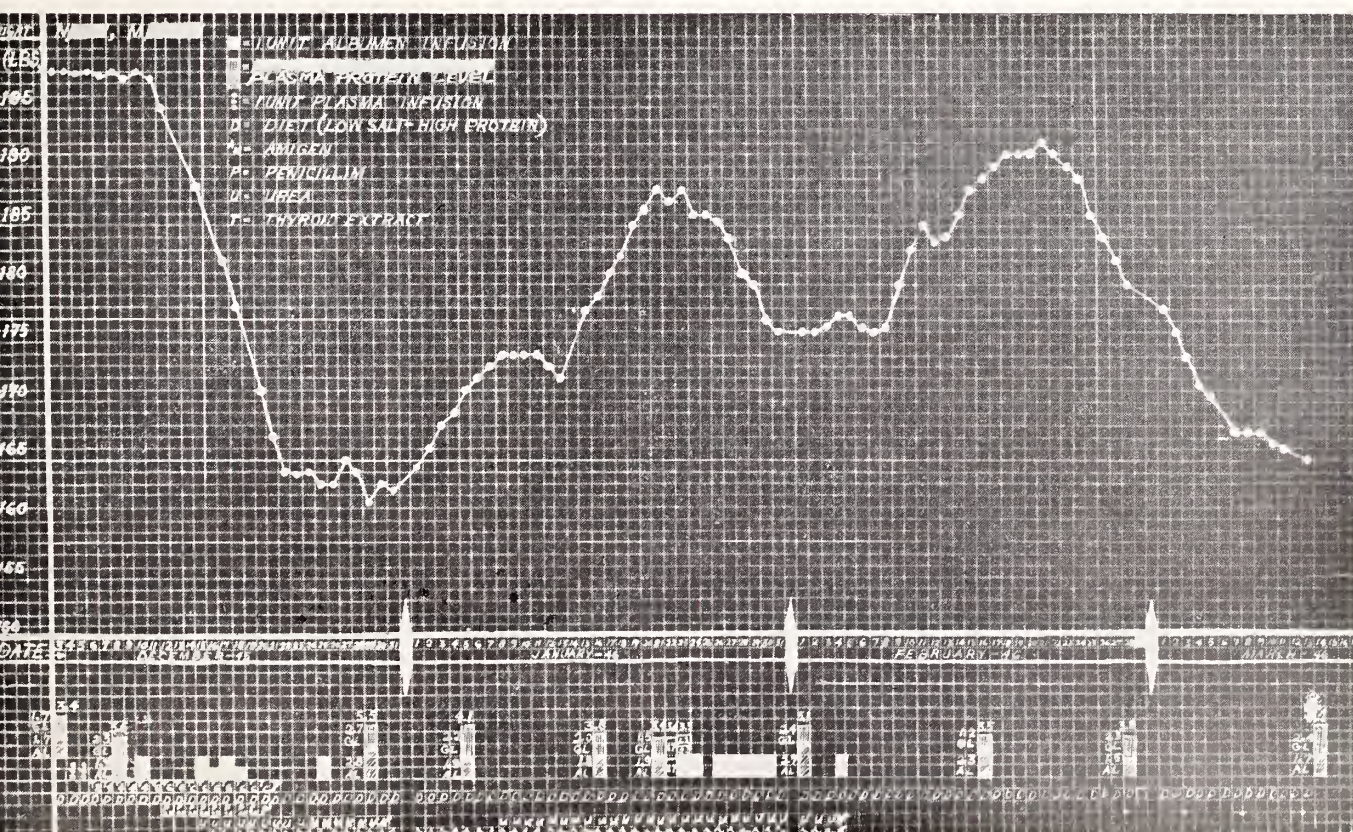




CASE No. I



CASE No. IV



CASE No. II



## CASE NO. III—D.L.S.

This 30 year old white soldier of Mexican ancestry was inducted into the Army in February 1942. He was feeling well until June 1945, at which time he noticed that he was unusually weak and tired after a long siege of strenuous combat. Shortly thereafter, his feet became swollen, and he developed a backache and dizzy spells which became progressively worse. He gave no history of preceding infectious diseases or any episodes of any previous kidney disease. He managed to continue his duties for two more weeks, but finally on August 21, 1945 he entered a hospital. Examination at this time revealed moderate edema of the extremities. Frequent urine examinations showed albumin varying in amounts from 1 to 3 plus. A moderate number of leukocytes were also found as well as few hyaline casts with only a few red blood cells. Plasma protein examination showed 5.9 grams per cent with 3.8 grams per cent of albumin and 2.1 grams per cent of globulin. The NPN was normal. An eosinophilia of 26 per cent was found, although several stool examinations for parasites were negative. Blood cholesterol was 620 mgm per cent.

*Hospital Course:* The patient developed a severe cough and pain in the left chest following his hospitalization. He coughed up bloodtinged sputum, vomited and had abdominal pain, although his temperature remained normal. White blood cells were increased to 18,000 per cubic millimeter. Sputum typings were negative for pneumococci, and sedimentation time was 64 mms in one hour. X-ray examination showed a left pleural effusion. Examination of the pleural fluid revealed a total protein of 27 mgs per cent. Urine concentration tests revealed maximum concentration of 1.018. The patient continued to have bouts of abdominal pain radiating to the left shoulder which were severe enough to require morphine on several occasions. About 10 days after the onset of this episode, he began to lose weight spontaneously. The patient was thought to have nephrosis and was transferred to the General Hospital on December 3, 1945. Physical examination revealed generalized edema. There were no signs of previous pleural effusions. Blood pressure was 110/80. Eye grounds were normal.

The following laboratory findings were reported on admission to this hospital: Serum protein was 2.7 grams per cent with 1.7 grams per cent of albumin and 1 gram per cent globulin, NPN was 30 mgm per cent, creatinin 1.3 grams per cent, blood cholesterol 242 mgm per cent. Sedimentation rate and BMR were normal. Wassermann and stool examination were negative. Routine blood count showed 4,100,000 red blood cells, 80 per cent hemoglobin, 9,750 white blood cells, differential of 52 per cent neutrophils, 32 per cent lymphocytes and 16 per cent eosinophiles. Examination of the urine showed consistent albumin of 1 to 3+ with occasional granular and hyaline casts, a few white blood cells and occasional red cells. Quantitative albumin determination in the urine showed 4,500 mg.

During his stay in this hospital, the patient's weight increased from 140 pounds to 149½ pounds. His edema progressed, and he was placed on a high carbohydrate, high protein, low salt diet without appreciable effect on his edema. Therefore, on December 10, 1945 he received an infusion of one unit of albumin. This was repeated on December 15, and on the following day he received two more units with-

out essential change in his condition. He was then put on 60 grams of amigen and 60 grams of urea daily. Massive infusions of albumin were started, giving two units daily for a period of 27 days. His last infusion was given January 19, 1946 by which time he had received a total of 62 units of albumin. His weight had dropped from 149½ pounds to 135 pounds. At this time, his plasma protein had increased to only 3.4 grams per cent with 2.3 grams per cent of albumin and 1.1 grams per cent of globulin. Symptomatically he felt much improved.

## CASE NO. IV—L.F.

This white soldier who was 21 years of age served as front line medical soldier for 22 months in the Southwest Pacific. Following a sore throat and an attack of diarrhea he noticed swelling of the ankles, which he treated himself. His urine was not examined during this period of time. He checked his diarrhea with sulphaguanidine. The swelling of his feet finally became so bad that he was unable to wear shoes. He was admitted to the hospital, at which time albumin and white blood cells were found in the urine. He was evacuated to the States, and on admission to the General Hospital his weight was 174 pounds. His blood pressure was 110/78 mm Hg. On physical examination there was noted marked edema of legs and sacral region.

*Laboratory Findings:* Numerous urine examinations showed albumin ranging from 2 to 4+ with occasional white blood cells and granular casts. Kidney function tests revealed the urea clearance to be 82 per cent, and the PSP excretion to be 52 per cent. This patient had 4,950,000 red blood cells per cmm with 15 grams of hemoglobin. Blood chemistry total protein was 3.4 grams per cent with 2.1 grams per cent of albumin and 1.3 grams per cent of globulin. Blood urea nitrogen was 11 mg per cent and cholesterol was 500 mg per cent. Sedimentation rate was 51 mm per hour, and ECG was normal.

*Hospital Course:* The patient was put on high carbohydrate, high protein and low salt diet with 30 grams of amigen daily. In addition, he received two units of albumin intravenously every day for nine days with clinical and symptomatic improvement. His plasma protein increased from 3.4 grams per cent with 2.1 grams per cent albumin and 1.3 grams per cent of globulin to 4.1 total protein with one gram per cent of globulin and 3.1 grams per cent of albumin after six units of albumin. This plasma protein level further increased to 4.6 grams per cent total protein after 18 units of albumin. The edema disappeared following this treatment and his weight dropped from 176 to 160 pounds. However, this gradually increased again to 170 pounds and his edema returned slightly but never reached the degree present before albumin treatment. The patient is feeling well and is on furlough at the present time.

## COMMENTS

The diagnosis in this case is difficult. The absence of red blood cells in the sediment on frequent urine examinations favor the diagnosis of nephrosis. The history of a preceding sore throat, however, leads one to consider glomerulo nephritis. It is possible that during the two months of self treatment, the



urine would have shown red blood cells if urinalysis had been performed.

#### CONCLUSIONS

1. In four patients with a nephrotic syndrome, plasma albumin infusions succeeded in increasing diuresis. The mechanism cannot be entirely explained on colloid osmotic pressure changes since diuresis took place even when the plasma protein levels were not markedly altered. Following this treatment, there was a mild weight gain, but not to the level prior to treatment.

2. Plasma albumin in amounts of 200 cc daily was given for long periods of time without production of pulmonary edema or increased red blood cell fragility in patients of a young age group. In older people or in patients with cardiovascular disease, pulmonary edema due to increased plasma volume may occur. For that reason, albumin should not be given at a rate faster than 5 cc in one minute and under close observation. The lungs should be frequently checked for the appearance of pulmonary edema.

3. Massive injections of plasma albumin failed to restore the normal plasma protein level at any time. This may be explained by the fact that the entire body is depleted of protein, that protein loss in the urine continues, and that the plasma volume increases. Due to the technical difficulties, plasma volume determinations could not be done in these cases.

4. Since amigen alone resulted in practically no diuresis and no change in plasma protein level, it is felt that amigen at least orally, was of little value in the treatment of these four cases.

5. Plasma albumin has an advantage over whole blood transfusions or plasma transfusions in that it

rarely produces chills, fever, urticaria or homologous icterus. It also contains less salt, and its colloid osmotic pressure is higher.

6. The success of plasma albumin was proven in all four cases by causing diuresis and decreasing nephrotic edema. Success seems to be only temporary, and considering the great cost of treatment, its practical value lies only in treatment of cases which do not respond to other less expensive medications. It can be used in cases of emergency, such as intercurrent infections, severe ascites, and pleural effusion due to nephrosis or chronic glomerulo-nephritis.

7. A renal crisis with disappearance of edema and marked loss of weight can occur without any treatment. It occurred in case No. 2. This should be considered in the evaluation of any treatment.

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## INDICATIONS FOR THE EXTRAPERITONEAL CESAREAN SECTION

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IN 1500, Jacob Nufer, a castrator of pigs at Sigerhausen, Switzerland, successfully operated upon his own wife after she had been given up by the barbers and midwives in attendance.\*<sup>1</sup> Since then progress has been slowly made toward a solution to the problem of the prolonged labor. The suturing of the uterus in 1769 by Lebas and the removal of the uterus by Porro represent steps in that progress. In 1907, Frank of Cologne first described a technique for the performance of extraperitoneal cesarean section; this was later modified by Latzko and others. However, it was not until the recent modifications of Waters and Ricci that the operation has been taken up with any fervor.

There has been a need for a long time for some definite obstetrical program for the patient in prolonged labor. When handled conservatively, the end result may be a dead baby and an exhausted and infected mother. A labor of thirty hours and over is considered prolonged. After fifty hours only about one half of the women deliver spontaneously and for those that need instrumental assistance 30 per cent are doomed to have a dead baby as the result. Intravenous fluids and sedation with morphine are only partial solutions to this problem. The timely use of the extraperitoneal cesarean section offers a positive approach.

There are three types of patients in whom the extraperitoneal section seems indicated. In general this type of section is designed for the infected or potentially infected patients in labor. Douglas<sup>2</sup> has demonstrated by cultures of the uterine cavity at cesarean section that after 8-12 hours of labor the uterine cavity harbors bacteria which were in the vagina at the onset of labor or introduced there during labor.

Obstetricians have come to recognize the so-called dystocia dystrophia type of patient who may have

a prolonged ineffectual labor. However, many of these patients have also unfavorable pelvis and unfavorable fetal positions or a combination of both. Premature rupture of the membranes seems to add to their difficulties. There is a definite problem here, however, since we cannot section all patients with posterior position or all patients with slightly unfavorable pelvis because most of these patients will eventually deliver normally. Thus far no one has found a satisfactory method of predicting which patients will have an inefficient labor which drag on into a matter of days instead of hours. Thus we not infrequently see the relatively normal patient who goes on hour after hour becoming more and more exhausted and a labor more and more ineffectual until infection is present and, unless something is done, the baby is lost. It is this situation which is partly responsible for the fact that reduction in fetal mortality has failed to keep pace with the reduction in the maternal mortality in the past ten years.

Another type is the "neglected patient" who has had an adequate indication for an elective cesarean section which has been overlooked. When the diagnosis is made, the patient is infected or potentially infected and is a candidate for an extraperitoneal cesarean section, cesarean section followed by hysterectomy or, if the baby is dead, a craniotomy.

There is a third type of patient in which the pelvis is borderline and the patient is subjected to a trial labor of several hours, after which if labor is progressing unsatisfactorily a low cervical cesarean section is usually performed. Frequently, too short a labor is allowed for an adequate trial or too long a trial labor is permitted for the safe performance of a low cervical section.

The following cases will serve as illustrative of situations in which extraperitoneal cesarean section is indicated:

\*Since this woman subsequently had five spontaneous labors, this operation, often erroneously called the first cesarean section, was probably the removal of an extrauterine child from the abdominal cavity.

1. C. Z., a 24 year old primigravida, had an uneventful antenatal course and clinically had a normal pelvis. Labor began at term 2 hours after premature rupture of the



membranes. She had painful contractions for 24 hours requiring sedation, but progress was exceedingly slow. After being given sedation with morphine and given intravenous fluids, labor continued without any appreciable dilatation of the cervix. At 40 hours, a sterile vaginal examination revealed the cervix to be half dilated and occiput to be directly posterior in mid-pelvis; six rectal examinations had been recorded. An extraperitoneal cesarean section was performed after forty-two hours of labor and ruptured membranes for forty-four hours. The temperature was normal at the time. Baby weighed 7 lbs. 14 oz.

For the first two days postoperative the temperature reached 100.2°F. then returned to normal. Sulfanilamide was used in the closure but no chemotherapy was used postoperatively. The patient was discharged on her twelfth postoperative day.

2. J. S. a 26 year old primigravida with a normal antenatal course and a clinically normal pelvis. The membranes ruptured at term and labor ensued within an hour but was ineffectual in character. In spite of infusions and rest with morphine when seen in consultation the patient had been in labor for 62 hours with ruptured membranes for 63 hours. The occiput was in mid-pelvis in ROP position and the cervix was about 5 cm. dilated, firm and rigid. The patient's body habitus was of the dystocia dystrophia type. An extraperitoneal section was performed. The baby weighed 8 lbs. 10 oz. Temperature reached 102.8°F. on the first postoperative day and gradually returned to normal over a six day period. Penicillin and sulfadiazine were used postoperatively. The patient was discharged from the hospital on her tenth postoperative day.

3. O. M. a 19 year old primigravida whose antenatal course was complicated by a mild pre-eclampsia and an engaged vertex at term. By X-ray pelvimetry the pelvis was android in contour with relatively normal measurements except for a 9.0 cm. transverse of the midplane. The patient ruptured the membranes prematurely and after 36 hours of labor had failed to engage the head which was wedged into the inlet of the pelvis; the cervix was 5 cm. dilated. The fetus was estimated at more than 3500 gm.

An extraperitoneal cesarean section was performed after 65 hours of ruptured membranes and 36 hours of labor; the temperature being normal at the time of operation. Undiagnosed twins weighed (a) 2500 gms. and (b) 1900 gms. During the postoperative course the temperature reached 101.8°F. on the second postoperative day and slowly returned to normal over six days. Sulfathiazole was used by mouth until the temperature had been normal for forty-eight hours. The patient was discharged on her fifteenth postoperative day; the twins were discharged after attaining 2500 gms.

4. H. C. a 24 year old primigravida admitted to Chelsea Naval Hospital. Her antenatal course was uneventful and her pelvis was clinically adequate, negative Kahn, positive Rh factor. Admitted to the Dependent's Unit at term in active labor, the cervix was 4 cm. dilated and position diagnosed as LOA slightly above the spines. The patient was inadvisedly heavily medicated on four occasions. Late in labor, by sterile vaginal examination, the position was determined to be LOP. At that time, the cervix was half dilated and no progress had been made for 30 hours. When seen by the author in consultation, the patient was exhausted, had

been in labor for 63 hours and had had ruptured membranes for 21 hours. Apparently each time she began to have effective labor, she had been given morphine and scopolamine until she was exhausted and no longer had effective pains. Temperature remained normal.

An extraperitoneal cesarean section was performed. The temperature reached 101°F. on the first and second postoperative days and then returned to normal. Sulfanilamide was used in the closure and penicillin postoperatively. The patient and baby, which weighed 7 lbs. 8 oz. at birth, were discharged on the twelfth postoperative day.

5. C. C. a 35 year old primigravida who had an uneventful antenatal course and was thought to have a clinically normal pelvis. Labor began at term and progressed slowly to full dilatation in 37 hours, the vertex at the spines in ROT position. Forceps failed on two occasions to effect delivery, although a good application of the forceps was possible. The temperature was normal at this time, and the membranes were ruptured.

An extraperitoneal cesarean section was done and a 9 lb. 8 oz. male child was delivered. Subsequent pelvimetry revealed an android pelvis adequate in all diameters, but clinical reexamination of the outlet showed the transverse and posterior sagittal diameters to be 7 cm. each. The size of the baby was a contributing factor in misjudging this pelvis.

The first day postoperative temperature was 99.6°F. and thereafter was normal. Moderate distention complicated her postoperative course. Sulfadiazine was administered by mouth until the temperature had been normal for forty-eight hours. She was discharged with her baby on the thirteenth postoperative day.

6. E. B. a 33 year old primigravida whose antenatal course was complicated by pre-eclampsia during the last month of her pregnancy. At the onset of labor there was an unexplained temperature of 100.4°F. Labor pains were poor. The baby was estimated at about 8 lbs. presenting by vertex at the spines. After twenty hours of poor labor, the cervix was 3-4 cm. dilated, firm and rigid. Twenty-four hours later, there had been little change except that the membranes now had been ruptured twenty-one hours. The amniotic fluid was meconium stained but the fetal heart remained good. The patient's temperature and toxemia status were unchanged.

An extraperitoneal cesarean section was performed after forty-four hours of labor and ruptured membranes for twenty-one hours. The baby weighed 3850 gms. It was in poor condition at birth and in spite of penicillin and oxygen therapy lived only twenty hours. The clinical diagnosis was septiceimia of the newborn and atelectasis. Autopsy showed alveolar and interstitial pneumonia besides cellulitis of the bowel. There were petechial hemorrhages throughout the pericardium, kidneys, adrenal glands, brain and lungs.

The postoperative course was complicated by a marked tracheobronchitis with questionable bronchopneumonia, x-ray indeterminate. With penicillin, the temperature slowly responded and the patient was discharged home on her eleventh postoperative day.

7. J. F. a 23 year old primigravida with an uneventful

antenatal course except for the finding of a flat pelvis confirmed by x-ray pelvimetry and an unengaged head at term. She was given a trial labor of thirteen hours, four hours of which were strong hard pains. With failure of the head to engage, a low cervical cesarean section was performed. The membranes were intact, but at operation there was a faint odor to the otherwise normal appearing amniotic fluid. The baby was an 8 lb. 4 oz. male in good condition.

On the first postoperative day the temperature rose to 102.5°F. Sulfadiazine and penicillin were begun. Temperature was 103.2°F. on the second postoperative day and normal on subsequent days. She was discharged on her eleventh day with her baby.

#### TECHNIQUE

The technique used in these cases was essentially that described by Waters.<sup>3</sup> The patient is prepared preoperatively with atropine and either spinal or general anesthesia is used depending upon the excitability and wishes of the patient. An indwelling catheter is connected to a sterile irrigating can containing a solution of methylene blue so that the bladder may be filled and emptied at will by raising or lowering the irrigating can. It is always well for the operator to test this apparatus himself since a full bladder does not make the operation impossible, it needlessly adds to the difficulties. In case No. 2, the operation was performed in spite of the patient's full bladder due to a blocked catheter. As suggested by Jellinghaus, if the head is wedged into the pelvis, it is displaced by sterile vaginal examination after the patient has been anesthetized in order to facilitate abdominal delivery of the baby.

A low midline incision is made down to the bladder. A T-shaped incision is then made in the perivesical fascia which covers the bladder. The operator will find it advantageous to operate from the right side of the patient for this facilitates demonstration of the point from which blunt dissection of the perivesical fascia from the posterior aspect of the bladder is begun. Here in the left paravesical space the peritoneum reflects on itself so as to form a fold which is easily recognized. No advantage has been found in finding this point first as recommended by Norton,<sup>4</sup> then incising the perivesical fascia. When the lower uterine segment has been reached, sufficient room to carry out the procedure is made by dissecting the peritoneum from the lower uterine segment and carrying the fold cephalad while the bladder is retracted downward and to the right side of the patient. The crescentic obliquely placed uterine incision has been found most satisfactory. The baby is extracted usually with forceps and the placenta removed. At this point pitocin is adminis-

tered intramuscularly to the patient or directly in the uterine musculature. The uterine incision closed with two continuous layers of No. 0 chrom catgut, the second suture line infolding the first. A medium sized Penrose sheath is placed down to the lower uterine segment behind the bladder and 5 gms. of sulfanilamide is dusted into the operative area. The abdomen is closed in layers, the drain being brought out at the lower angle of the incision.

A retention catheter is placed in the bladder to keep it decompressed until the drain is removed. The drain is loosened on the third postoperative day and removed by the fifth postoperative day. Penicillin or sulfadiazine or both are used as indicated.

#### DISCUSSION

The first three cases here presented fall into the first category, that is, patients in whom there was no definite indication for cesarean section at the onset of labor. Two of these patients had posterior vertex positions and the third had undiagnosed twins, yet all had inefficient labors. All were at least potentially infected and had been in labor for forty-two, sixty-two, and thirty-six hours with ruptured membranes for forty-four, sixty-three and fifty-six hours respectively. That they might have eventually delivered from below is admitted, but that all three would have had living babies and a smooth convalescence is extremely doubtful, if conservative methods had been followed. I believe that the decision in cases of ineffectual labor should be made sometimes between thirty-six and fifty hours of labor, in order that the patient may not be subjected to infection and that the baby may be salvaged. I go without saying that if the mother has had an intrauterine infection for any length of time the baby is potentially or actually infected. Douglas and Stander<sup>5</sup> in a study of the effects of prolonged labor on the baby state that "prolonged labor per se exerts a deleterious effect on both the maternal and fetal organisms and the severity of this deleterious effect increased progressively with the duration of labor. These authors noted that the increase in fetal mortality is not very marked prior to the elapse of forty-eight hours after the onset of labor, but that a very sudden increase occurred in labors lasting forty-nine to sixty hours and a still further increase in those labors lasting longer than sixty hours. About half of their cases of prolonged labor delivered spontaneously, and the fetal mortality was only slightly increased in these, however in those who were delivered by operative means (forceps and breech extraction).



the mortality rate approached 30 per cent. Under the circumstances of prolonged labor they often observed the death of the fetus in utero. A fetal bacteremia was found in a large percentage of these infants who succumbed to prolonged labor, and the organism most commonly found was the anaerobic streptococcus. They felt that infection was probably responsible for these deaths.

Thus it becomes apparent that there is a deadline as far as the baby is concerned in making a decision to deliver the patient by extraperitoneal section. If the decision is put off too long the indication to save the baby is no longer valid since the baby may well succumb in utero or later in the neonatal period from infection. Although abdominal delivery beyond the fifty hour limit is possible and may result in a live baby, the chances are progressively poorer. However, even beyond this point the procedure may be worth while maternally in that it is often less traumatic than a difficult operative delivery from below with its attending extensive soft tissue damage. In the event that the cervix is dilated enough to effect delivery by craniotomy it is the procedure of choice if the baby is dead.

Case No. 6 illustrates the fact that fetal salvage is not always possible. This baby had a septicemia at the time of operation which was borne out by the clinical and autopsy findings. The most likely explanation of this septicemia is that it was secondary to a temporary bacteremia in the mother, a not unusual finding at the onset of a pulmonary infection. The meconium stained amniotic fluid indicated fetal distress long before delivery. An intrauterine infection although not completely ruled out as the cause of the intrapartum infection seemed unlikely in view of the postpartum course being that of a pulmonary complication. Regardless of the outcome to the baby, extraperitoneal cesarean section offered a way out of an already prolonged labor in a patient with pre-eclampsia and an intrapartum infection. Conservative treatment had little to offer. Spontaneous delivery seemed extremely doubtful at the best in view of lack of progress for twenty-four hours. The fetal indication was not strong enough to warrant operation in this case.

In the neglected cases it is obvious that the sooner the correct diagnosis is made the better is the chance for the baby. However, often the consultant will not see these cases until late in labor when intrapartum infection has relatively been long present. In that event even though the fetal heart is still good the consultant must bear in mind that fetal salvage cannot be counted upon. It is in the potentially infected or early case of intrapartum infection that the extraperitoneal section has the most to offer in this category. Cases 4 and 5 illustrate this point.

The third indication for this procedure is the case in which a trial labor fails. In the fifth case here presented, the patient ran an extremely stormy course in spite of penicillin and sulfadiazine. There seems to be no reason other than convention for withholding the extraperitoneal section in all such cases.

#### CONCLUSION

1. The extraperitoneal cesarean section is indicated in (1) prolonged labor in which a spontaneous outcome seems improbable; (2) the so-called dystocia dystrophia syndrome; (3) "neglected cases" and (4) failed trial labor.

2. In the first and second categories the decision to perform extraperitoneal cesarean section should be made between thirty-six and fifty hours of labor.

I wish to express my thanks to Dr. H. Freeman Pennington for permission to use cases No. 5 and No. 6 in this report.

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## OCCUPATIONAL MEDICINE AND ITS RELATIONSHIP TO PRESENT DAY INDUSTRIAL RELATIONS

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AMERICA has learned one big lesson from the war: that when employe and employer really and truly cooperate in the interests of all-out production, the output of their factories and businesses cannot only be doubled but in some cases trebled. This is not theory, it is the actual war production record of the greatest industrial country in the world. The record will stand for all time, as proof of what free labor and free management working together can achieve. The good employe-employer relationships which existed during the war was somewhat enhanced by a sense of duty and patriotism on the part of management and labor. In addition there were war-time government restrictions placed on both. In the wake of the war these reasons no longer exist.

The war has conclusively proved the costliness and foolishness of industrial strife, bickering and misunderstandings. The successful business today must concern itself seriously with building sound relationships with their employes and failure to promote better human relations will result in the failure of our system of free enterprise and free labor. The situation is a challenge to the leaders of both management and labor who are jointly responsible for industrial relations. Upon them must fall the task of "selling" the importance of cooperation to both labor and management. Upon them depends, more than upon any other group, the creation of an employe-employer environment which will be a firm foundation for an enlightened labor-management relationship.

An attempt will be made in this paper to show that our present day concept of occupational medicine will help to create and maintain health, security, happiness and good morale in industry. In order to

do this it will be necessary to review briefly the history and course which medicine has taken in industry.

There are many who believe that the change and progress made in industrial medical practice during the past twenty years have been largely due to the efforts of those engaged in industrial medical work. This is a common misconception; the fact are that industry itself is largely responsible. However, some credit must be given to a certain minority group of physicians who have contributed much to the progress made in this specialized field of medicine. In order to prove this, one need only to consider some of the fundamental reasons why industry ever became interested in this profession. Although industrial medicine has been recognized for centuries it was not until the State Compensation Law imposed financial hardships on industries that doctors became a necessity. Industry very soon realized that their operation costs and profits were seriously influenced by loss of manpower resulting from injuries. From a Compensation standpoint, two things had to be done to remain in business. First, to provide adequate treatment to the injured; secondly (and much more important than the first from a cost standpoint), the reduction and possible prevention of all accidents. This program required assistance from two professions, namely, doctors and engineers. The emphasis, as I will attempt to show you, was always placed on prevention.

The physicians engaged by the industries to treat the injured were usually surgeons. In many instances however, physicians were engaged with little or no special training in surgery. Most always this physician, if he remained in industry, would sooner or later become a surgeon, whether or not he sought out surgery as a specialty. Many of our middle-aged and older surgeons today have attained their surgical experience and prominence via this route. I am informed that this type of surgical residency is now



virtually non existent. There are perhaps two reasons for this; first, because of the policies set up by the surgical boards; secondly, because of the effectiveness of industry's preventive surgical program. In the average industrial city today with a total population of 100,000, there isn't enough major industrial surgery to keep one man busy.

Proud of their efforts in preventive surgery, industry began to explore more deeply the field of preventive medicine. It was reasonable to presume that a worker with all of his facilities and in good health would not get hurt or lose time from work as readily as those who had physical or mental disabilities. These conclusions lead many industries to inaugurate a pre-employment physical examination program which was essentially a screening process. Applicants who had physical or mental defects were not accepted for employment. Labor, in general, reacted unfavorably to this plan. The war altered this policy. Many of the physically and mentally handicapped who were previously rejected for employment were now satisfactorily placed in industry. Consequently the pre-employment or screening physical examination is now called "the pre-placement physical examination."

Most surgeons were too busy to participate in this new phase of industrial medicine. Industry then turned to the medical profession in general for assistance and the surgeon dropped out of the scene. As the program proved itself valuable the examinations were extended to older employees; this plan served at once to establish a satisfactory relationship between the workers and the medical department. Employees with treatable defects were referred to their personal physicians or to proper agencies for supervision. Occasionally during the examination itself it was possible to do some effective health education work. The findings on examination might have revealed the necessity for a job transfer in the interest of health and safety of fellow workers or of a whole department. A timely job transfer might be the means of delaying total disability in the face of a chronic, slowly progressing illness.

Later the program was made to include partial examinations of employees who became ill while at work, and also employees returning to work following an absence due to illness. A full program also included periodic partial examinations of employees known to be working with toxic materials and the accumulated records were made the subject of constant study and review. The information gained was

correlated with the knowledge of production men and hygiene and safety engineers concerning the working environments of the employees.

Today many of our industries and businesses are equipped with elaborate hospitals and staffed by full-time nurses, physicians, and clerks. The scope of work in organizations with this type of medical service is outlined briefly as follows:

1. Complete pre-employment and periodic physical examinations on all employees, including: chest x-rays, blood counts, serological tests, urine analyses, electrocardiograms and basal metabolism tests.
2. Treatment of all occupational injuries and diseases. Minor conditions are most always cared for by the existing plant medical staff. Major cases are referred to specialists in the various fields; surgeons, oculists, dermatologists, dentists, orthopedists, psychiatrists, urologists, etc.
3. Plant sanitation and hygiene:
  - a. Water supply; b. general housekeeping; c. illumination; d. air conditioning; e. noise control.
4. Personal hygiene for workers:
  - a. Toilets and washrooms; b. fatigue control; c. nutrition—lunch room; d. housing; e. recreation; f. mental hygiene.
5. Coordination of industrial and community health service:
  - a. Communicable disease control; b. industrial waste control; c. vital statistics; d. health and safety codes and regulations.
6. Industrial health exposures:
  - a. Abnormalities of air pressure; b. abnormalities of temperature and humidity; c. dampness; d. dusts; e. infections; f. radiant energy; g. poisons; h. essential toxicology and safe concentration codes.
7. Plant surveys:
  - a. Identification of exposures; b. sampling apparatus and analytical methods; c. control of exposures and maintenance of controls.
8. Job and worker analyses:
  - a. Aptitude and psychologic tests; b. hours of work; c. shifts—night work; d. women in industry; e. environmental factors; f. peak loads.
9. Statistics:
  - a. Incidence, costs and classification of industrial accidents, occupational diseases and non occupational disabilities.
10. Workmen's compensation:
  - a. Administrative methods, regulations and insur-

ance practices; b. employment of the physically handicapped.

11. Industrial relations plans:

a. Insurance plans; b. sickness and accident benefits; c. pensions.

12. Rehabilitation.

Within the past several years, the unions have taken a very active interest in the subject of occupational medicine, health security and welfare. In many instances where adequate medical service was not available in industry they have taken the initiative. It was extremely unfortunate that certain industries and industrial physicians were recently indicted because of this failure to provide adequate occupational hygiene measures for their employees.

Industry through the organization of scientific means for insurance against disease, for its cure and prevention, have an agency within their grasp, perfectly legitimate in its nature, to offset some of the most destructive forms of radicalism, and to protect their workers from the fear that they will be left alone and helpless when they are sick. This is a legitimate motive only insofar as you actually create and provide far better agencies than would otherwise be at hand. Working people are far more subject to charlatanism in medicine, which preys upon superstition and fear, than are other classes. If we can lift the veil of superstition and show the value of scientific prevention and diagnosis, we can leave the cures to take care of themselves. But both prevention and diagnosis are serious and costly

studies, and cannot be undertaken lightly or from any purely selfish point of view. The problem, therefore, if it is to be attacked comprehensively, must be by a combined attack, from the humanitarian, the protective, and the economic points of view. Each one of these offers a true incentive when it is sincerely used, and each suggests its own method of procedure. Taken together, they accumulate a foundation upon which the most effective medical department can be built up and maintained.

The old time industrial physician no longer exists in our most progressive companies today. Employees referred to him many times as "saw-bones" and too often associated him with accidents and a witness against them in compensation cases. Today the employee's health is a major concern of many of our successful companies and the attainment and maintenance of any employee's health is the primary objective of occupational medicine—true preventive medicine. In industries where this concept has been put in practice you will invariably find good employee-employer relationships.

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## THE LIBEL SUITS OF THE AMERICAN MEDICAL ASSOCIATION

MORRIS FISHBEIN, M.D., *Chicago*

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The Author. *Editor of the Journal of the American Medical Association*

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ONE of the hazards of publishing is the possibility of being compelled to defend suits for libel or damages by those who have seen their reputations disappear, their profits diminish, their livelihoods destroyed, following exposés. The power of the press should never be minimized. Publication of the

facts day after day or even in a single powerful exposé may be sufficient to destroy a false promotional venture in the field of health in a single day.

#### TWO LOW-GRADE COLLEGES

The campaign of the American Medical Association against unqualified medical schools and against proprietorship in medical education brought two suits against the Association soon after the turn of the century. These suits were filed by medical col-

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leges which found themselves suddenly without students or repute before the state boards of examiners. Evidently those who filed the suits discovered very soon that they had nothing to gain, and the suits were withdrawn. The schools that filed these suits died soon after.

#### THE "WINE OF CARDUI" SUIT

In 1916 a suit began in the District Court of the United States in the Northern District of Illinois. It was filed by John A. Patten and Zeboim C. Patten, Jr., doing business under the name of the Chattanooga Medicine Company vs. the American Medical Association and George H. Simons. Two suits were filed, the second by John A. Patten alone against the same defendants.

On April 11 and July 18, 1914, *The Journal of the American Medical Association* published articles dealing with Wine of Cardui, a product manufactured by the Chattanooga Medicine Company. These articles declared, among other things, that the business of the Chattanooga Medicine Company had been built on deceit and that Wine of Cardui was a vicious fraud.

The personal suit of John A. Patten asked \$200,000 damages and the company suit asked for \$100,000 damages. The cases came to trial on March 21, 1916. In the middle of the trial on April 26 John A. Patten died and the personal suit automatically ended. The partnership case was continued and the case went to the jury on June 16. The jury brought in a verdict for the plaintiff but assessed the damages at one cent.

This was the first of the important suits defended by the Association. The opening statement for the plaintiff to the jury rehashed the old unwarranted charge that the American Medical Association was a monopoly and a trust, that it was opposed to self-medication and opposed to all sorts of proprietary products. The attorneys for the Association pointed out that neither of the Pattens was a physician, that none of those associated with them was a physician and that their nostrum sold all over the United States, could not possibly cure the diseases for which it was offered. The attorneys said,

"With full knowledge of the fact that at least one-fifth or more than one-fifth of every bottle of Wine of Cardui, prior to 1906, that Mr. Patten was putting out on the market, was pure alcohol, he was nevertheless satisfied that the business should continue with the representation to the purchasing public that it was positively non-intoxicating."

The company had put out over 20,000,000 almanacs known as the "Ladies' Birthday Almanac." They had also put out a statement that their "Home Treatment for Women" was a valuable book for the ladies who have any sort of female trouble and their slogan read:

"Lest you may have some serious female trouble that is working on you, buy a bottle of Wine of Cardui today, and be taking it while you are getting this book; price \$1.00 a bottle. Or what is better, if you will buy 5 bottles, we will throw in a bottle. All orders cash; nobody trusted."

It had been one of the claims for the Wine of Cardui that it would lift up a fallen womb or uterus.

Mr. John A. Patten was closely connected with the Methodist Church. On this subject Mr. T. J. Scofield commented:

"I do not care whether he is the bishop of the Methodist Church; I do not care whether he is a high layman in the Methodist Church; I do not care whether he is at the head of the book committee of the Methodist Church, when any man tells you that in a case of prolapsed womb, chronically so, with its ligaments stretched until the womb is practically hanging out of the body—that Wine of Cardui, the miserable nostrum that we contend it is, and that we said it was in these articles, and say now, will pull that womb up into its natural position in the human body until it has reached its ascendancy and there rests, is a matter of such absurdity that it would seem to me that common intelligence would deny the truth of such representation, and yet that is one of the representations which they (the plaintiffs) make."

I cannot tell here the whole story of the trial or reproduce any considerable amount of the evidence. For the Association appeared some of the leading chemists, toxicologists, gynecologists, obstetricians and other expert witnesses in the entire United States. One finds among them such names as those of Drs. Joseph B. DeLee, Charles A. L. Reed, J. Clarence Webster, Torald Sollmann, Frank Billings, and Hugh McKenna.

The principal ingredient of Wine of Cardui was viburnum prunifolium, a herb remedy, and also another herb known as carduus benedictus. The jury was enlightened on amenorrhea, headaches, puberty and many similar subjects. This case demonstrated, among the earliest of such cases, how difficult it is to make a jury of laymen, uninstructed in any of the medical sciences, understand the problems

concerned in the diagnosis and treatment of disease. After Dr. Frank Billings had testified for many hours and just before he left the witness stand, Mr. W. M. Hough, an attorney for the Wine of Cardui company, said to him:

Mr. Hough: Q.—Just before you get off the stand, doctor, will you explain to the jury the difference between puberty and nubility? A.—And what?

Q.—The difference between puberty and nubility? A.—I don't get your last word.

Q.—Nubility. A.—Nubility?

Q.—N-u-b-i-l-i-t-y? A.—Nubility; you've got me.

In preparation for this case the investigators had toured the south and had found great numbers of instances of men who were using this alcoholic nostrum as drink.

Among the amusing evidence was one of the questions placed to Dr. J. Clarence Webster, in his time one of the most distinguished gynecologists in the United States. He was asked particularly as to whether or not it was possible by the taking of any drugs to elevate a uterus which had fallen from its position because of relaxation of the ligaments. He pointed out that it had been impossible in any number of experiments to effect such relaxation by the use of any one of a great number of drugs, including all of those concerned in Wine of Cardui. His cross examination extended for many days since he had actually done experiments with all of the drugs concerned. Apparently the attorneys for the Pattens considered his testimony very damaging. Dr. J. Clarence Webster declared that one could no more raise the uterus by drugs after relaxing of the ligaments than one could put stretch back into a pair of worn out garters by dropping them in alcohol.

In his instructions to the jury, the Hon. Judge George A. Carpenter pointed out that certain statements that had been published in *The Journal* for July 18, 1914, had been libelous per se. "Libel," said the court, "is a malicious defamation expressed in writing or by signs or pictures or by epitaphs tending to impeach the honesty, integrity, virtue or reputation of a person and thereby to expose him to public hatred, contempt, ridicule or obloquy and cause him to be shunned or avoided or to injure him in business or reputation." The court continued:

"These statements, I tell you, are libelous per se in that they charge that the plaintiffs were guilty of perpetrating a fraud upon women who purchased Wine of Cardui, in manufacturing and putting the same upon the market as a woman's tonic possessing

medicinal value, with full knowledge, actual or constructive, that it was worthless and produced no medicinal effect except from its alcoholic content.

"In order to justify this charge it will be necessary for the defendants to prove: First, that Wine of Cardui is worthless and produces no medicinal effect except from its alcoholic content; and, second, that the plaintiffs had knowledge or should have known of such fact while manufacturing Wine of Cardui and placing it upon the market."

Two defenses had been urged. One was justification and the other qualified privilege or fair comment.

As to the defense of qualified privilege, the Court stated that any person may discuss a matter of private concern provided, first, that he has not been moved by actual malice and, second, that his comment and criticism shall be fair and reasonable. The Court pointed out that the American Medical Association in writing the articles about Wine of Cardui was treating a matter of great public concern. In the discussion of a public matter if any person publishes of another a fair and reasonable comment of his conduct of business and the publisher is not actuated by any element of actual malice, then that publication is privileged, and there may be no recovery whatever because of that publication. Fair and reasonable comment does not include a reckless disregard of the truth or any statement inspired by malice or evil intent. In his charge to the jury, the judge pointed out that if this were the case of John A. Patten, which the court emphasized it was not since John A. Patten had died, complaints might justly have been made that the articles of the defendants did overstep the bounds of fair comment and criticism or qualified privilege. "It was not necessary," said the Court, "in the interest of humanity for the defendants to criticize Mr. Patten in his church relations." . . . "But this suit involves," the Court continued, "purely a business proposition and no consideration may be paid by you to the feelings of the surviving partner, however lacerated they may be, or to the feelings of his family, however keenly his family and relatives may have suffered."

The judge then discussed in considerable detail the question of damages. After being out nearly a week, the jury brought in a verdict for the plaintiff and assessed the damages at one cent.

The Association considered this a notable victory. The public had been enlightened. The worthlessness of the nostrum had been demonstrated. The patent



medicine purveyors now realized the Association would not only publish but also fight!

#### TWO SUITS WITHOUT RECORD

Somewhere in the first ten years of the 1900's two suits were filed by one E. P. Cooke and one Mary A. Duns, but there is no report in any available record of these suits.

#### HENRY J. SCHIRESON VS. MORRIS FISHBEIN, ET AL.

Shortly after Dr. Morris Fishbein assumed the editorship of *The Journal of the American Medical Association* and undertook an active campaign against quacks, frauds and nostrums of many types, the suits began to multiply. Among the earliest was the suit of Henry Junius Schireson, notorious plastic surgeon with a long record of imposition on the public.

In 1911 Schireson with some other individuals incorporated the "Shirpost Medical Office" in Chicago—a quack concern that advertised in foreign newspapers. At the same time he was connected with the European Medical Institute, also called the People's Medical Dispensary of Cleveland, Ohio. He was also associated with a "medical institute" in Scranton, Pa.

In 1911 he applied to the Illinois State Board of Health for a license to be given to him by reciprocity on the basis of a license issued to him by the Vermont State Board of Medical Registration in February 1909. In his application Schireson stated that he had taken his first and second years in medical college at the Maryland University from October 1902 to May 1904. The actual evidence showed that he had never entered Maryland University until October 1903 when he entered as a freshman but that he failed in all branches, except histology and medical jurisprudence. Further investigation showed that Schireson was not in attendance at the Maryland Medical College for 1904-1905, but that he did attend one course of lectures at the Maryland Medical College in 1905-1906 and was given a diploma from that school in 1906. The Illinois State Board refused to give him a license.

In May, 1912, Schireson was arrested in Detroit because he had obtained a license in Michigan on the basis of forged credentials and his license was cancelled. In Pittsburgh, to which he next moved his headquarters, he ran an advertising office and paid "protection" to two county detectives. He was convicted and sentenced and was pardoned after serving two months because he turned state's evidence. In

1914 he was arrested in New York City for practicing medicine without a license and in 1915 he was sentenced to six months in the penitentiary for violating the penal laws of New York. After leaving the penitentiary, he opened an office in Utica under the name of Dr. Fanning and took in \$36,000 in six weeks as a result of "swindling the immigrant population of Oneida County." At the same time he had an office in Schenectady where he took in \$14,000. Then he obtained a diploma from a notorious diploma mill in Kansas City, Missouri, and in 1922 got himself a license in Connecticut through the eclectic board of that state. Early in 1924 his Connecticut license was revoked on the ground of fraud and deceit.

In 1921 he had secured a license from the Department of Registration and Education in the State of Illinois in spite of the fact that the state had previously refused him a license. This license was granted during the incumbency of a director of the department, named W. H. H. Miller, who later was convicted of selling licenses and fined \$1,000.

Now came the heyday of Schireson's career. He set himself up as a specialist in plastic surgery and the straightening of cross-eyes. He hired a press agent who later sued him for \$50,000 on a charge that Schireson had never paid him adequately for his press agency. The press agent charged that he had persuaded Fannie Brice to submit to an operation by Schireson as well as many other notable persons, including Lady Diana Manners. In 1927 Schireson got a lot of publicity in connection with an alleged surgical job on Peaches Browning.

Schireson's biggest mistake came in 1928. A young woman went to him to have a burn on one of her shoulders treated. He suggested to her that he would straighten out her legs. He did the operation at an osteopathic hospital. The legs became gangrenous and both had to be amputated at the knee in order to save her life.

In January of 1930 Schireson was found guilty of fraud, conduct unbecoming a physician and gross malpractice, and his Illinois license was revoked. In 1931 his license was revoked in Ohio following charges of gross immorality, conviction of a felony and grossly unprofessional or dishonest conduct.

His most recent career has been in Philadelphia. The Philadelphia Sunday *Transcript* in 1937 gave a detailed account of Schireson's bankruptcy case; there were so many judgments against him in behalf of former patients who had brought damage suits

that he pleaded bankruptcy. In 1939 he was indicted by a Federal Grand Jury in Philadelphia charged with hiding \$130,000 from his creditors while filing a petition of bankruptcy in 1937. He was also indicted on a perjury charge as a result of testifying that he was not married and that he did not live in Merchantville, New Jersey. As a result he was sentenced to serve two concurrent terms of eighteen months in the Lewisburg Federal Penitentiary.

This is the charlatan who brought two suits against Dr. Morris Fishbein on the charge that he had been libeled. During his stay in Illinois he brought nuisance suits and tried repeatedly to force the presence of the editor of *The Journal* in court, once arranging to have a bailiff serve a subpoena on the editor just after he had boarded the Twentieth Century for an important trip.

As late as June 25, 1946, the Supreme Court of Pennsylvania affirmed the decision of the Court of Common Pleas of Dauphin County upholding the contention of attorneys for the state board of medical education and licensure that the state licensing body had the inherent right to revoke a license obtained by fraud. Schireson had been trying by injunctions to restrain the state board from revoking his license.

The story of Henry Junius Schireson is proof that he is supreme among plastic surgeon quacks.

None of the suits of Henry J. Schireson against Dr. Morris Fishbein ever came to trial.

#### HOXIDE CANCER INSTITUTE

Next came a suit of the Hoxide Cancer Institute against the American Medical Association and against Dr. Morris Fishbein. The record of Hoxsey in the field of cancer quackery is one of the longest in the history of American medicine. On January 2, 1926, *The Journal* published a three page article dealing with the quack remedy put out by Harry M. Hoxsey. At that time the Hoxide cancer cure was exploited from Taylorville, a town in central Illinois, and was sponsored by the Chamber of Commerce of that town. Hoxsey's father was John C. Hoxsey who had dabbled in veterinary medicine, faith healing and cancer cures. In 1919 John C. Hoxsey died of cancer. In 1924 Harry M. Hoxsey joined with a Dr. Bruce Miller and an insurance man in setting up something called the "National Cancer Research Institute and Clinic." Their treatment was essentially the use of an escharotic or caustic substance with arsenic as its base. The idea of these caustics is that they can eat off a cancer. No

such treatment has ever cured a cancer—occasionally the caustic eats off a considerable portion of the skin in addition to the cancer.

After the exposé of the Hoxide cancer cure in 1926 and again in 1929, Hoxsey became associated with Norman Baker of Muscatine, Iowa. Then he headed an alleged cancer clinic in Detroit where he was found guilty May 8, 1931, of practicing medicine without a license and sentenced to serve six months in the Detroit House of Correction.

On July 11, 1941, he was charged in Dallas, Texas of practicing medicine without a license and fined \$25,000 and court costs. He continues at this very time to operate a cancer clinic in Dallas, Texas. No Hoxide libel suit has ever come to trial.

#### ELECTROPHONE CORPORATION

Next came a suit from the Electrophone Corporation against the American Medical Association. The electrophone was an elaborate device exploited from Chicago. It had been originally called the "Deafone." It was put on the market by a concern which was first known as the National Acoustic Laboratories and then as the National Deafone Company and still later as the Electrophone Corporation. The instrument was used in a so-called Audio Institute which advertised, "Hearing restored by the Audio treatment." The electrophone was a bogus hearing device. The suit never came to trial.

#### PERCIVAL LEMON CLARK

On March 31, 1928, *The Journal of the American Medical Association* published a long article about a quack named Percival Lemon Clark who was the promoter of a system of healing called "sanatology." Clark was born in 1866 and had received a diploma in 1889 from the Bennett Medical College, Chicago, which was then an eclectic institution. He conducted a health school and a health home and called himself dean of the world's first university of sanatology. Clark even got some bills introduced before the Illinois legislature to get legal recognition for sanatology. He urged that acidosis and toxicosis are the two basic causes of all disease. He did not believe in the germ theory. He claimed to cure asthma. He also sold a dextrinized health school brand of laxative foods and a "Sanatology Blower," which it was claimed "would dry clean the entire system and rejuvenate."

He exploited a "Sanatology Enema Bag and Attachments" which removed the "toxic poison from the body." This was just a hot water bottle with



ose. The patient would insert the nozzle in the rectum and then sit on the hot water bottle. The weight of the body was supposed to force the water up into the intestines.

He also purveyed "Sanatological Oil," "Laxative Salts," and a book called "How to Live and Eat for Health."

For a while he promoted his health home and his system over the radio station owned by the Chicago Federation of Labor, known as WCFL, a name which it still bears. He used to come on about 7 o'clock at night and utter such slogans as "The whiter the bread, the sooner you're dead." "The more sugar you soak, the quicker you croak."

He filed a suit against the American Medical Association for \$3,000,000. Following the discovery by further investigations that he had an unsavory record in Canada where he had on one occasion been involved with the police, the suits that he had filed against the Association were dismissed by the courts in 1933.

#### ORA-NOID

On March 9, 1929, *The Journal* published an exposé of a product called Ora-Noid, said to be synthetic saliva. The suit was filed against Morris Fishbein and the American Medical Association and was for \$1,000,000 for libel. The chemists of the American Medical Association had found that Ora-Noid was essentially a mixture of table salt, baking soda, chalk, magnesia, starch and borax. This mixture was being sold as a cure for pyorrhea. In 1933 this case was also dismissed on motion of the plaintiff.

#### JOHN R. BRINKLEY

John R. Brinkley might well be characterized as the greatest charlatan in medical history. His many suits against Dr. Morris Fishbein and the American Medical Association at different times came to many millions of dollars. His first suit was filed at Junction City, Kansas. Finally a suit came to trial in Del Rio, Texas, on March 22, 1939. That suit was based on an article published in *Hygeia* entitled "Modern Medical Charlatans."

On May 26, 1942, the Associated Press spread throughout the world the obituary notice of John R. Brinkley, M.D., Ph.D., M.C., LL.D., D.P.H., Sc.D., Lieut. USNR. Said the A.P.: "Death today closed the turbulent medical, political and radio career of Dr. John Richard Brinkley, 56, rejuvenation surgeon known popularly as 'the goat gland doctor.'" The *New York Times*, perhaps profligate of space, gave

him a column and a half with a picture. He was, at the time of his death, one of the most widely known citizens of the United States. He was also by common consent the greatest charlatan the world has ever known.

By his own testimony John Romulus Brinkley, as he later called himself, was born in Beta Jackson County, in western North Carolina in 1885.

The boy attended the mountain schools of the neighborhood—little one-room shacks with one teacher trying to inform children of many different ages about reading, writing, arithmetic, history, geography, music, drawing and kindred matters and to act simultaneously as school physician, nurse, physical educator and inculcator of etiquette.

When Brinkley was sixteen years old, he obtained a position carrying the mail from the post office in the mountains to the railroad station. Here he became acquainted with the railroad agent, who gave him a chance as assistant to learn telegraphy, railroad bookkeeping and how to run a railroad station.

The next event in the life of Brinkley was no doubt the pivotal point which embarked him on a career of charlatanism. He went from Sylva, North Carolina, to Baltimore to see about getting into Johns Hopkins University; that was the only medical school he had ever heard of at the time. Again I quote:

"Going up there I found I did not have enough education to enter the school, and I met a man while I was there in Baltimore that had another school there that prepared young men for school entrance requirements, and while I didn't stay there and attend the school with him, yet he furnished me with books to read and outlined a plan of study for me and I went on up to New York City and worked in New York City for quite a while for Western Union. Then I worked for the Central Railroad in New Jersey—Hoboken, New Jersey. During that time I was doing I suppose today what we would call one of these correspondent courses like we have outlined. I would go down to Baltimore occasionally and report how I was getting along and be quizzed and first one thing and another. I left New York in 1906 because my aunt who raised me was in feeble condition. I returned to North Carolina and she died in December of 1906 and was buried, and I married and I went to Chicago and got a job with the Western Union Telegraph Company and found out about Bennett Medical College in Chicago and matriculated in Bennett College in June 1908 and worked

for Western Union of a night and went to school of a day. And the first year I was in school there in Bennett Dr. John Dill Robertson, who was president of the school, established a literary department that he called the Jefferson Park College, I believe it was. During our freshman year in Bennett we freshmen that wanted to take literary work outside of our medical work would go over to this Jefferson Park College at three o'clock in the afternoon and spend a couple of hours over there in study until five. I had to leave at five o'clock because I had to be down at the Western Union office at 5:30 to go to work, and that is the way my time was occupied the freshman year."

Brinkley declared under oath that he got his preliminary education at Milton Academy, Baltimore, and was in attendance there from September 1902 to July 1906, when he was given a diploma. Also, when applying for license in California, he did not file any diploma but presented a photograph of a letter written on the letterhead of Milton Academy and purportedly signed by William J. Heaps. Three Baltimore persons deposed that they had attended Milton Academy (day sessions) some time between 1902 and 1906 and did not recall Brinkley. A Dr. Snively who taught at the school in the same period deposed that he did not remember Brinkley. Also, he said that the alleged signature of Heaps on the photographed letter previously mentioned was a forgery. Heaps was said to have been one of the persons on whom Brinkley claimed to have performed a goat-gland operation. In connection with Milton Academy, there was also what was known as the Milton University, which Brinkley claimed had given him a B.A. degree. The same Mr. Heaps has been quoted as saying that he conferred this on Brinkley as an honorary degree for the work he had done and the reputation that he enjoyed.

Brinkley did not get into the senior year at the Bennett Medical College. He owed a large sum for back tuition. Dr. Robertson was accustomed to permit students to enter short of money, but no one could enter the senior year in debt to the school. It was "pay up or get out," according to Brinkley, so he got out.

Brinkley had entered the Bennett College in 1908, and he remained until the fall of 1910. He missed about six weeks and returned early in November. During those six weeks he was a telegrapher in Montreal and in New York.

The next three years of his life determined his career in quackery. During the summer and fall of 1911 Brinkley practiced medicine in western North Carolina without a license but with a permit of the secretary of the medical board. Brinkley went to Miami for a few weeks in the winter and worked as a telegrapher. Then restlessness seized him. He went back to Whiteville, North Carolina, then to St. Louis, then to Tennessee where he got an undergraduate's license based on three years of the kind of education he had. He was at Danrich, Tennessee during the first half of 1912, in Knoxville during the last half.

Late in the spring of 1913, John Brinkley was in Chicago. In Lincoln Park a long line of prospective swimmers stood in line to rent bathing suits so they could cool off in Lake Michigan. Among them was Brinkley. The man at the wicket told him the lockers were all rented but that he could, if he wished, share a locker with its occupant. By this adventure, opportunity knocked at Brinkley's door. This was the tide in his affairs which, taken at the flood, led on to fortune. In the locker was James L. Crawford. Brinkley told how he had worked for one Burke, operator of several venereal disease quackeries in Knoxville and in Chattanooga. Crawford and Brinkley decided to return to Burke and set up an establishment under his direction. Together they went to Chattanooga for some graduate study on how to operate a venereal disease quackery; then they opened up in Greenville, South Carolina, with a big sign that read "Greenville Electro Medic Specialists." When they arrived in Greenville, they had ten dollars between them and starvation. They got credit at the drug store for rent and supplies, credit with the press for their advertisements. About the time the American press was informing the world about the advantages of salvarsan and neosalvarsan—"606" and "914"—Ehrlich's magic bullets—for syphilis. The word went out that these itinerant physicians had these remedies, available at twenty-five dollars per injection. Actually according to Crawford, they injected colored water. Crawford it seems had given up mayhem for the more refined career of medical practice. When seen in 1938, he was serving a sentence of eighteen months in the Oklahoma penitentiary for robbery with firearms at the Hotel May in Tulsa. Previously he had a home address in the federal prison at Leavenworth, Kansas, for transporting a stolen motor car. The Council on Medical Education of the American Medical Association has



not yet accepted these experiences as prerequisites for medical education and licensure.

Now time plays strange tricks with our memories. Somewhere in the period between 1911 and 1915 Brinkley or a man of the same name was arrested for forgery in Tennessee. He was never able to remember the details. One day he and Crawford departed from Greenville leaving a number of unpaid bills behind them. By the processes of the law they were returned and lodged with the sheriff for forty-eight hours. The sheriff produced a number of rubber checks, the kind that bounce back, signed by the electromedical specialists. Our hero departed for new pastures, greener than Greenville. Somewhere in this period Brinkley was in St. Louis because he turned up with a diploma from the National University of Arts and Science at St. Louis, although even from that nondescript institution one cannot obtain the record showing he was ever a student. His record, full of chicanery and deception, was unctuated with licenses, diplomas, citations, subpoenas, court orders, bad checks, election ballots, bonds and mortgages. In these days of paper shortage, his accumulation would be more valuable as scrap than ever it was for documentary purposes. He had a diploma from the Eclectic College of Medicine or the Eclectic Medical University of Kansas City. When the class graduated, all went, accompanied by a professor, to Arkansas, where they were licensed to practice by the Eclectic Board. In 1921 the Connecticut Eclectic Board gave Brinkley a license. By 1923 it was discovered that many an Eclectic Board was issuing licenses somewhat at random, and Connecticut revoked the one they gave Brinkley. Once he went to California under a temporary license to try his hand at rejuvenating an aging and decrepit publisher. For a few weeks of what turned out to be a useless effort, Brinkley got fifty thousand dollars. After he got back to Kansas, where he resided, he was indicted in California, and they sent emissaries to Kansas, but he didn't go back.

In May of 1915 Brinkley was licensed in Arkansas; in June in Tennessee. He tried practice in Memphis without success, moved on to Judsonia, Arkansas, but crops were ruined by a flood; then he went on to Fulton, Kansas, and practiced there, finally arriving in Milford, Kansas—just a wide space in the road—in October 1917. There he remained until 1933. From time to time he visited Chicago and New York. He once visited Shanghai and collected five thousand dollars for a few operations. The Royal

University of Pavia, on one of his trips, granted him an honorary diploma which was later annulled. There was also a sort of certificate issued in England, which was also annulled.

On one of the pamphlets issued by Brinkley later in his career appear the letters M.D., C.M., DR.P.H., SC.D., following his name. He said the SC.D. came from the Chicago Law School, the Doctor of Public Health from the Eclectic Medical University of Kansas City. These alphabetic appendages have become the mark of the charlatan. Brinkley also had an LL.D. When asked where he got it, he said, "I will declare I don't know!"

Now how did the famous goat-gland operation originate? Here is his story:

"A very peculiar circumstance happened at Milford, Kansas. I had only been there about two weeks, being a new doctor in town and having a little drug store that I had opened up there, and different country people would drop into the drug store to meet the new doctor and pay me their respects and tell me they were glad I was there and so forth. This one man came in and got to talking with me about sexual weakness. I told him I didn't know anything that would do him any particular good as to sexual weakness. The conversation continued and we got to talking about why couldn't we take some glands out of an animal and put them into a man. I told him it was biologically impossible. He wanted to know why it was impossible. I told him because you couldn't transplant the glands from a higher order of animal kingdom to a lower or vice versa. He wanted to know how I knew you couldn't, and I told him that was what I had been taught and I believed it. To make a long story short, he furnished the animal and I transplanted some glands into him, with good results according to his statements to me. I had advised the man not to have it done and he said, 'You are a surgeon. You can put them in and if they spoil you can take them out.' To me the results were amazing and startling because I expected bad results and disastrous results and instead of that happily results were obtained. The man claimed that he had been sexually dead for sixteen years. His wife verified that statement. A year later I delivered his wife of a fine baby boy, which at least proved that he was fertile, anyhow. Of course the news got around in great fashion, and a cousin of his came to me and asked me to do the same thing on him and I did and he had me to transplant glands into his wife. Then one of their relatives was in the insane hospital in

Nebraska. He had been a banker. He was a banker up there, he was a cashier and lost his mind and was placed in an insane institution. They wanted to know from me if I thought glands would do this insane person any good, and I said, 'Lord God no,' and they said, 'We want you to try it' because he had been a masturbator and 'We know it' and they brought him down there, took him out of the institution, and I put those glands into him and that man recovered his mind and today is in charge of one of the biggest banks in Kansas City, Missouri. He came out of the insane asylum in Nebraska and had these glands put in. I published that in an article in a little magazine, and down in Alabama a lady read it. She had a daughter that had been in the insane asylum for ten years in Tuscaloosa, Alabama. She was violently insane at times. When she went to get a permit, she had to get a state permit to get this daughter out of a padded cell, they had to keep her in what is called a padded cell to keep her from doing injury to herself; she was trying all the time to commit suicide. And my wife and I met this lady with her daughter in Memphis, Tennessee, and put her in a drawing room and brought her to Kansas City and over to Milford. I transplanted glands into that young lady. She stayed in my hospital for a month, fully recovered her mental capacity. She didn't want to go home because she felt she was disgraced because of her previous life. She secured a secretarial position in Kansas City, Missouri, and married a physician and today she is healthy and happy and normal."

In the meantime publicity began to come to the scientific sage of Milford. The early 1920's marked the beginnings in the United States of the new profession of public relations council. Publicity hounds of many varieties sniffed their way into the newspapers. The Sunday supplements carried stories of the rejuvenator who preached and who practiced goat-gland science. Brinkley had allied himself closely with the local church. He had given Milford as a gift the Brinkley Methodist Memorial Church bearing a tablet which read, "Erected to God and

His Son Jesus in appreciation of the many blessings conferred upon me, By J. R. Brinkley." The Lord takes the blame for many mundane affairs when the responsibility may not always seem clear.

Eventually the fame of the rejuvenator reached California. Here is the story of the beginning of the first Brinkley radio station, KFKB:

"I had been called by Harry Chandler, the owner of the Los Angeles *Times* in Los Angeles, California, who had read a little article I had written and published in some magazine some place and he asked me to come out there; an old employee at the time was sick. Mr. Chandler wanted me to put these glands into him to see if it would do him any good. While I was there, Chandler was having installed KHJ for the *Times*. I think it was the first radio station that was ever put in there in Los Angeles, California. And leaving California and going back to Milford I thought it would be a nice thing to entertain the patients by having a radio station close to the hospital where they could lay in bed and listen in on their earphones, and I bought the station and gave lectures over it, talked about various diseases of the human body and did that up until 1929. I never tried to produce any patients over the radio at a never even made any effort to. I was using the radio up until 1929 to give musical entertainment and medical lectures and medical advice in a general way. In 1929 I began a series of lectures dealing with the diseases of children. I began to receive an enormous amount of mail from people asking me about this thing and that thing and another thing. I couldn't answer it, and the only way it could be answered was to go on the radio and answer a good bulk of it, and in 1929 from answering those letters over the radio, through the radio, patients began to come to me because of radio advertising."

The right to operate a radio station was easily secured in those early days of commercial radio. Now the growth of the influence of the Federal Radio Commission puts rigid restrictions around broadcasting and station ownership.

*(To be continued)*



# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### A Call To Duty

From many points of view the recent annual meeting of the State Medical Society was most successful. The attendance at the scientific meetings and commercial exhibits was far beyond that which was expected. The House of Delegates also was marked by a full attendance and the dispatch by which the business of the Society was conducted should be flattering to those who directed the meeting. Noticeable at the annual meeting were many new faces, also many who have been absent from our community for varying periods during the war years. To these new members, about one hundred of whom have joined the Society but recently we have a particular duty, for we must see to it that they become familiar with what goes on in the meetings of the House of Delegates, the Council, the office of the Executive Secretary and other of our affairs. They should also learn the important relation of the County Medical Societies to the larger Society, for in the former much of the policy of the latter has its formation. A voice in the county society is often heard throughout the whole organization. New members of the Society themselves have a duty in seeking to understand the processes which govern an organization which can mean so much in their professional life. A duty of similar nature, we regret to say, falls upon some indifferent older members who failing to inform themselves about the workings of the House of Delegates and the Council are often unfairly critical of the Society.

A statement which the Committee on Public Relations of the State Society has so frequently emphasized that "every" physician is a public relations officer for the Society" is a truth so important that it should be the serious concern of every member of the profession. One has but to read the daily news to be impressed as to the kind of thinking that is going on in Congress with regard to medical affairs. In one way or another national legislation in the not so distant future is going to impress itself on the life of every practicing physician. To guide such thinking into proper channels is the grave concern of all of us. Only by working together in county and state societies can we present a front which will be realistic and intelligent. This means that all members, new and old, must understand the democratic processes which govern the State Medical Society, become familiar with its objectives and take an active part in its deliberations—it is your Society, it is your opportunity.

### A Matter of Opinion

The recent rejection by the State Senate of House Bill No. 953 which would liberalize the present contraceptive law so that physicians could prescribe such measures for health purposes brings to an end another attempt for legislative change in which the doctors of our state have had no inconsiderable interest. The proposed amendment had a great deal of public support as is witnessed by the report of the Committee and its passage by the House of

Representatives by a significant majority. Passage of the proposed bill was also endorsed by the House of Delegates at the annual meeting of our Society, an action supporting a previous vote concerning a similar bill formerly introduced. With some physicians in our Society opposition to the measure is a matter of personal conviction and it is noteworthy that at no time during the present controversy was there any evidence on the part of physicians of a lack of respect for such opinion either on the part of those who opposed or those who favored the bill. This may have been a disappointment to some lay individuals who have not yet realized that physicians have been respecting each others opinions for a matter of centuries. It is certain that the next regular convention of our Legislature will see a further attempt to modify the present law, and that in the meantime efforts will be made to create public opinion for and against such change. In any event the solidarity of the physicians of Connecticut will not suffer. We shall continue to respect one another's opinions in the future as in the past, for among those whose chief purpose in life is the study of their fellow human beings there long has been a considerable knowledge and respect for their processes of thought.

### The 22nd Clinical Congress

The 22nd Clinical Congress of the Connecticut State Medical Society will be held in New Haven September 16, 17, 18, 1947. Under the auspices of a committee of the Yale School of Medicine working in cooperation with the Society, the Congress has become a medical event of major importance in our state. Its consistent success over the years is due not only to the excellence of the speakers who have been obtained but also to the wise policy of changing the type of program from time to time. This year the pattern will be essentially similar to that of last year, morning speakers at the general session with luncheon question and answer period, followed in the afternoon by symposia and panel discussion. The registration fee will remain the same, \$3 for Society members and \$5 for non members, medical students and members of hospital staffs admitted without fee. Dr. Arthur J. Geiger of New Haven is chairman of the program committee, and Dr. Courtney C. Bishop of New Haven chairman of the arrangements committee. Other members of the Committee from the School of Medicine are Drs. F. G. Blake, Herbert Thoms, D. C. Darrow, H. B. Shumacher, F. C. Redlich, H. M. Wilson, W. R. Wilson.

### The Rising Hospital Costs

The increase in hospital rates of which we are painfully aware should be considered with sympathetic understanding if we are to be fair to hospital management and the public which it and we serve. Hospital costs are already beyond the means of an individual of the moderate income if he is not insured, and in prolonged illness such costs may be prohibitive even among the insured. The comparison of hospitals to hotels is not justified when we consider the great increase in personnel required by the former and the ever expanding need for diagnostic and therapeutic equipment. Furthermore, hospitals in addition to serving the public directly must continue to serve indirectly through training programs for both nurses and physicians. In comment upon this problem Dr. Frank A. Weiser recently stated:

"Relief from high costs must come from monies donated either by private individuals or by the government to supplement the income of the hospitals. Our present income and gift tax setup make it prohibitive for private citizens to give amounts sufficiently large to affect the cost picture, hence appears aid will have to come from tax monies either through grants directly to hospitals or by the building of government owned and managed institutions."

"A more efficient method would be to free donations, to accredited hospitals, of the gift tax and permit their deduction from the income tax. Thus the full amount would go to the hospital (and hence to the public) without the erosion that occurs when monies flow through government channels."

### Report of Atomic Bomb Casualty Commission

In the report of the Atomic Bomb Casualty Commission at a recent press conference held in the office of the U. S. Army's Surgeon General a number of interesting facts relating to the Japanese survivors of Hiroshima and Nagasaki were disclosed. The members of the commission were Dr. Austin M. Brues, associate professor of medicine at the University of Chicago; Dr. Paul S. Henshaw of the Clinton Laboratories at Oak Ridge, Tennessee; Captain Melvin A. Block and Lieutenant James V. Neel of the U. S. Army; and Lieutenant (j.g.) Frederick V. Ullrich of the Naval Medical Research Institute, Bethesda, Maryland. The report, based upon a six weeks' visit to Japan between November, 1946 and January, 1947, was necessarily limited in scope and



included some material obtained at second hand from Japanese observers.

The principal direct observation made by the commission had to do with the large number of burns that healed with excessive quantities of scar tissue having relatively flat, elevated surfaces and sharply defined margins. These resembled ordinary keloids and varied in size from plaques one centimeter in diameter to areas involving most of the face or back.

The commission also reported observations of Professor Tsuzuki on a study conducted in October and November, 1945, relative to the spermatozoa of 124 male inhabitants of Hiroshima. In 43 instances the number of spermatozoa was less than 5,000 per cubic millimeter and indicated absolute sterility. Ten other cases were relatively sterile. The remaining 71 were normal. However, an increase in abnormal forms was recorded and considered an indication for further study.

Dr. Tsuzuki reported that women who were in an early stage of pregnancy had taken a normal course after the bombing.

The principal evidence for gene mutations came from the studies of Dr. Takeo Furuno, a noted horticulturist, who maintained two experimental garden plots, one 150 meters from the hypocenter of the explosion, the other 500 meters. Dr. Furuno observed abnormal vegetative forms of several plants grown from seed in the plot nearer the hypocenter. The commission inspected both plots and arrived at the opinion that soil differences complicated the picture to the point where no definite conclusions could be reached.

The study of the commission threw little light on the possible incidence of reproductive disturbances, congenital abnormalities, malignancies, alterations of the life span or other latent potentialities. It is conceivable that mutations of recessive genes might lead to physical monstrosities only after several generations. The commission concluded that much valuable information could be obtained from a long term study of atomic bomb casualties. It would be well to have the results of that study in hand before we recklessly render the land, sea, and air radioactive by the wholesale use of atomic weapons.

### Senator Murray Again

Senator Murray has introduced the democratic health scheme for 1947, S1320, and has picked up additional sponsorship; Senators Chavez, New Mexico; Taylor, Idaho; and McGrath, Rhode Island.

Although the bill contains much wordage concerning decentralization of administration, this one really goes all the way in placing medical care under bureaucratic control. In not so roundabout fashion, it proposes that the Social Security Administrator, Watson B. Miller, be given complete control over the health of the nation and the practice of medicine. Mr. Miller would be the Administrator and second to him would come Surgeon General Parran and Arthur Altmeyer, Commissioner of Social Security.

The usual silent hocus pocus is included so no one knows whether the new bill is in fact an insurance measure or just another raid on the Treasury in the form of a one per cent supplementary tax. If it is this, it constitutes another income tax for the people. Most observers see it in this light.

In the analysis of the bill provided by the United Public Health League, it is pointed out that it covers some groups not provided for in the 1945 and 1946 versions. These are civilian federal employees and their dependents and state and local governments may, by voluntary action, cover their employees and their dependents. Needy persons can be provided for as in the 1945-1946 bill through action by state and local governments, paying premiums for these persons into the health insurance fund. The new bill makes special provisions for rural areas; expands and makes more explicit the guarantees of professional rights to doctors, dentists and hospitals; removes the ceiling on the per diem payments to hospitals; and makes numerous additional changes based on criticisms and suggestions expressed in the hearing on the previous bills.

Provision is made for supplying all kinds of diagnostic and curative services by a family physician of the patient's choice and services of specialists when required; hospital care, laboratory x-ray services, unusually expensive medicine, special appliances and eye glasses. Dental, home nursing and auxiliary service may be limited in extent if personnel, facilities or funds are inadequate. All employed and self employed persons are covered, including employees in industries, commerce, agriculture, and domestic service, employees of non profit institutions, farmers and other persons in business for themselves. Recipients of old age or survivors benefits or civil service pensions will be covered. The wives, children under eighteen, disabled husbands and dependent parents of all these insured persons are covered. Needy persons who are not insured through their own earnings will qualify if contributions are paid on their behalf by a public agency.

The financing involves some sort of fiscal magic and relies upon an annual appropriation to the National Health Insurance Fund of an amount equal to three per cent of earnings which presumably will come from social insurance premiums to be levied one half on employed persons, one half on their employers. The three per cent is to be calculated on earnings up to \$3,600 a year.

Argument is already under way and Senator Pepper at the hearing attempted to point out how much the people would receive under this new cradle to grave protection. Said Senator Pepper, "This Murray bill would give every person eligible a complete yearly examination, laboratory tests, etc." This big offer did not impress Senator Donnell who replied, "If 135 million people are to receive a yearly examination and there are 135 thousand practicing physicians in this country, assuming it would require two hours of the physician's time, each doctor would spend, examining patients, forty hours per week during the entire year." It is forecast that this measure will create less commotion before the 80th Congress than Mr. Murray has been able to provide in the past.

### Streptomycin Therapy of Pulmonary Tuberculosis

The isolation in 1944 of a potent anti-bacterial agent by Waksman and his collaborators from the "ray fungus," *Actinomyces griseus*, opened a new and promising field of anti-bacterial therapy for human tuberculosis. This agent, known as streptomycin, has been the object of considerable investigation during the past several years. While the place of streptomycin in tuberculosis therapy has not yet been clearly defined as a result of these studies, it does appear that this agent not only effectively inhibits the growth of the tubercle bacillus in the test tube, but also may significantly alter the clinical course of human pulmonary tuberculosis when administered in adequate dosage for prolonged periods.

In the Fall of 1946, a cooperative clinical study by eight civilian sanatoria and hospitals was undertaken by agreement between and under the sponsorship of a number of manufacturers and the American Trudeau Society. The Laurel Heights State Tuberculosis Sanatorium and Yale University School of Medicine combined efforts in Connecticut as one of the eight centers in the study to investigate the effect of streptomycin upon pulmonary tuberculosis. This group very recently gave a preliminary report

of their findings before the Yale Medical Society. In this report, the clinical effect, the development of resistance of the tubercle bacillus, and the toxic manifestations occurring as a result of such therapy were considered.

While the accurate evaluation of any new form of therapy for tuberculosis is notoriously difficult, it would appear from this study that striking improvement was noted in over half of the patients treated at Laurel Heights. In a group of 16 patients, improvement was noted as "very striking" in 5, "exceptionally good" in 4, and "moderate" in 5. In 1 patient there was no improvement.

The excellent response of tuberculosis endobronchial lesions in these patients was particularly noteworthy. These lesions, present in 8 of the 16 patients prior to treatment, all healed under streptomycin therapy although one such lesion promptly recurred after the development of organisms resistant to streptomycin.

Streptomycin, however, is still far from being the ideal drug for the treatment of tuberculosis because of certain severe toxic manifestations that may occur following administration of this drug for a prolonged period. Of particular importance among these toxic manifestations is the loss of vestibular function in a high percentage of the cases treated. In some instances this toxic reaction upon the labyrinth was particularly severe. The mechanism of this reaction is not known. Though rare, impairment of hearing is occasionally encountered, and occurred in one patient treated at Laurel Heights.

The appearance of streptomycin resistant strains of the tubercle bacillus during the course of such therapy was disturbing and constitutes a serious problem. Such strains ordinarily appear after two or three months of streptomycin therapy in those patients who continue to exhibit positive cultures.

While it is difficult at the present time to evaluate the proper place of streptomycin in the therapy of pulmonary tuberculosis, it is suggested that the greatest use of the drug may prove to be as an adjuvant to the treatment of tuberculosis by conventional therapeutic measures such as bed rest, phrenic paralysis, pneumothorax, and thoracoplasty. The long term significance of the vestibular disturbance, and of drug resistant strains of organisms are not yet known. Hence, physicians are warned against indiscriminate use of streptomycin, especially in patients whose prognosis with conventional methods of therapy is good."



Further nationwide studies are now in progress to determine the type of tuberculosis which best responds to streptomycin therapy and to more clearly establish proper dosage and spacing of the drug.

## Multiple Sclerosis Group

Announcement has been made of the formation of the Association for Advancement of Research on Multiple Sclerosis with headquarters at the Academy of Medicine in New York. This organization was initiated by a group of multiple sclerosis patients themselves, together with many friends and cooperation with some of the leading neurologists in this country. The purposes of the new association are to:

1. Coordinate research efforts on multiple sclerosis in this country and abroad;
2. Gather statistics on its prevalence and geographical distribution;
3. Act as clearing house for information on this disease;
4. Educate the public on the problem of multiple sclerosis;
5. Collect funds to stimulate and support research on multiple sclerosis and allied diseases.

At the present time the association plans to conduct a nationwide membership drive to enroll multiple sclerosis patients as well as the public. It is expected that important statistical data concerning the disease now lacking can then be obtained. Connecticut is represented on the Board of Sponsors by the Hon. Brian McMahon, United States Senator, and on the Medical Advisory Board by Dr. James C. Fox, Jr.

Little is known about the cause or the cure of multiple sclerosis. Research on this disease thus far has been hampered because of lack of financial resources. Moreover, it has been uncoordinated for want of an organized means to ascertain what research is being done in the field and thereby effect a systematic plan for future research activity. Yet, surveys made in Baltimore and Boston indicate that multiple sclerosis is more prevalent than infantile paralysis. The disease can have an incapacitating effect on young people in all walks of life, thus creating a serious social problem which is deserving of the financial support of the public. It is hoped that organized and correlated research will shed light and help find the solution to multiple sclerosis.

## Still the Shame of the State

*(Editorial Hartford Times, May 23, 1947)*

The unanimous vote of the State Senate creating a seven-member commission to consider the building needs of the State mental hospitals, the training schools, the care of the chronically ill, aged and

infirm, and the tuberculosis sanatoria, follows similar action in the House.

Creation of this commission is good as far as it goes, but it is little more than putting off what needs to be done now. It effectively postpones for two years any improvements in the bad conditions in the State mental hospitals, unless a special session should be called to deal with them.

It will not asperse any individual to say that a seven-member commission can produce no new facts about conditions within the State mental hospitals, or within the other institutions linked together in the new commission. The needs of the State mental hospitals are well known. What is needed is action. There always can be a new commission, and it always can be a means of preventing action.

The political powers that be are not individually callous. They want to "keep down the cost of government." That is always the excuse for evasion of duty, always the "out" for not appropriating money that as a mere humane act should be appropriated, no matter how much selfish or penny-pinching people might protest.

If the proposed commission, with a miserable \$1,000 to spend on its survey, can produce a plan of operating the State's humane and welfare institutions that will be scientifically sound and will result in provision by the Legislature of the \$22,000,000 needed for capital expenditures, then it will have worked a first-class miracle. We would like to witness that miracle, but we are frankly doubtful of it.

What is needed is an examination of conscience by the Governor, the political State committees and the legislators, to the end that before the next session opens a bond issue will be voted to provide the buildings, the repairs, the equipment and the attention this emergency presents. What is to be avoided is any bedevilling of the needs of the State mental hospitals by mixing them up with other less urgent needs.

To accomplish this desirable end before the next session opens would require a special session of the Legislature. That already has been suggested in discussion in the Senate of the new commission. The idea deserves favorable consideration. Proper medical, physical and psychiatric treatment of more than 8,000 unfortunate people put in the care of the State demands prompt action. Until they are corrected, conditions in the State mental hospitals will continue to be the Shame of Connecticut.

## THE PRESIDENT'S PAGE

INTELLIGENT physicians who wish to know what the future holds in store for medical practice should make a habit of reading the London News Letter in the *Journal of the American Medical Association*. The British people in many ways are like ourselves and we can study with profit the struggle which the medical profession in England is making to preserve liberty in the face of economic conditions such as we do not fully appreciate in this country.

Socialization of medicine, now almost completed in England, has been taking place steadily during three decades. A panel practice for the low income groups with a capitation system of payment was acceptable to British physicians, because it furnished financial support for their poorer patients, but particularly because physicians were able to maintain fee-for-service practice among their more fortunate clientele. This latter group has grown progressively smaller and further regimentation of medical services is demanded by more patients and is being tolerated by more physicians as a direct consequence of economic pressure.

Regimentation is tolerated in the face of national disaster. It has no place as a dominant pattern in our country where economic conditions are more fortunate.

My purpose in directing your attention to the situation in England is to remind you that the pressure towards socialization of medicine will become stronger when times are bad as indeed they may well be ere long. We need more well informed physicians who give time to the consideration of the conditions underlying their position in society.

James R. Miller



## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

*Providence-Journal Photo*

At the 136th annual meeting of the Rhode Island Medical Society Councilman Frederic C. Barnes, representing Mayor Dennis J. Roberts, presents the Dr. Charles V. Chapin Award of the City of Providence to Dr. Stanhope Bayne-Jones, of New Haven, second from right. Observing the ceremony are Dr. Herman C. Pitts, left, president of the Society, and Dr. Frank T. Fulton, anniversary dinner chairman.

The Connecticut State Medical Society was represented at the meeting by Dr. Cole B. Gibson, Merident, treasurer and past president; Dr. Joseph H. Howard, Bridgeport, past president; Dr. Creighton Barker, New Haven, executive secretary; and Dr. William J. H. Fischer, of Milford, whose son, Dr. William J. Fischer, Jr., is practicing medicine in Providence. The meeting was held in Providence on May 14.



## 1947 CLINICAL CONGRESS

Francis G. Blake, Dean of the Yale School of Medicine and Chairman of the Committee on the Clinical Congress, has announced that the 1947 Congress will be held in New Haven on September 16, 17, and 18. The Committee arranging the Congress consists of Francis G. Blake, Herbert Thoms, Arthur J. Geiger, Courtney C. Bishop, Harry B. Shumacker, Jr., Hugh M. Wilson, William R. Wilson, Frederick C. Redlich, Daniel C. Darrow. Dr. Geiger is the Chairman of the Program Committee and Dr. Bishop is the Chairman of the Committee on Arrangements.

### Annual Meeting of the Council

The Council held its Annual Meeting on May 16. There were present, the Chairman, Dr. Murdock and Drs. Harvey, Howard, Parmelee, Phillips, Weed, Gibson, LaMoure, Thoms, Miller, Burlingame, Weld, Barker, and Miss Mooney. Excused, Drs. Gildersleeve and Speight. C. Charles Burlingame, newly elected Councilor from Hartford County, and Samuel C. Harvey, president-elect, met with the Council for the first time.

Thomas P. Murdock was re-elected chairman of the Council for the coming year. According to custom an Executive Committee was appointed to act for the Council during the summer vacation period. This committee consists of the president, the president-elect, the chairman of the Council, and the executive secretary. Meetings during June, July and August will be omitted but special meetings may be called by the chairman.

#### NEW MEMBERS OF THE BOARD OF TRUSTEES OF THE BUILDING FUND

In accordance with a resolution of the House of Delegates on April 28, five additional members were appointed to the Board of Trustees, making a total of ten members. The newly appointed members are: Edmund L. Douglass, Groton; Raymond A. Gandy, Stamford; Michael E. Giobbe, Torrington; Donald J. McCrann, Hartford; and Edward J. Ottenheimer, Willimantic.

#### APPOINTMENT TO STATE BOARD OF EXAMINERS FOR PHYSIOTHERAPY TECHNICIANS

It was voted to recommend to the Governor H. Bruno Arnold for appointment as a member of the Board of Examiners for Physiotherapy Technicians, as is required by statute. Dr. Arnold has subsequently received this appointment from the Governor.

#### COMMITTEE ON THE CHRONICALLY ILL

In accordance with a resolution of the House of Delegates on April 28, the Council appointed the following Committee on the Chronically Ill: George

A. Wulp, Hartford, chairman; Richard I. Barstow, Norfolk; A. Nowell Creadick, New Haven; and Charles H. Sprague, Bridgeport.

#### SURVEY OF THE SOCIETY'S INVESTMENTS

The secretary reported the results of a conference with the vice-president and trust officer of the Second National Bank relative to the investment of the Society's surplus. Recommendation was made that no change be made at the present time in the Society's investment policy.

#### CHANGE IN BY-LAWS RELATIVE TO DUES PAYMENT

Long discussion was entered into by the Council concerning changes in the By-laws to permit remission of dues in certain cases and the method for placing members on the exempt list for longevity. The secretary was instructed to prepare amendments to the By-laws for consideration by the Council at a later date and presentation to the House of Delegates at its semi-annual meeting later this year.

The Council adjourned for dinner at 6:00 P. M. and was joined by Dr. Speight.

### Separated From Military Service

The following members of the Society have been returned to civilian status from military service:

Brier, Hyman D., Bridgeport (A)  
Carlson, Robert I., New Haven (A)  
Paley, Isaac M., Stamford (A)  
Penner, Sidney L., Stratford (A)

### Dr. Cox Honored by Ensign Bickford Employees

Ralph B. Cox of Collinsville, for more than forty years physician at the Avon plant of the Ensign Bickford Company until his retirement December 31, 1946, was presented a silver tray recently by employees at Avon as a token of appreciation of his long service. He will be succeeded as plant physician by William M. Wiepert of Avon.



## CENTENARY — AMERICAN MEDICAL ASSOCIATION — ATLANTIC CITY

### JUNE 8-13, 1947

**I**F THE founders of the American Medical Association, such men as Nathan Smith Davis of New York and Jonathan Knight of Connecticut, could have viewed the throng of over 15,000 physicians in attendance at the centennial celebration they would have been not only astounded but thrilled. Breaking all records in attendance physicians gathered from all parts of the United States and indeed from all parts of the globe. One of the most impressive features of the entire session was the introduction of guests representing medical societies and their governments on every continent and many an island of this globe. Like the Wise Men of old they came bearing gifts. Beginning with the representative of the British Medical Association who presented a gavel and block made of wood from the mulberry tree formerly growing in the yard of Charles Dickens, continuing with representatives from Iceland, Norway, Denmark, Switzerland, Belgium, Cuba, Argentina, Australia, Egypt, Saudi Arabia, Iraq and Iran, and ending with the brilliant young Chinese scholar, it was a continuing procession of the world's greatest medical talent. The scroll from the Chinese Medical Association was very appropriate. Picturing a pine tree, symbolic of longevity, it was beautifully inscribed in Chinese characters with an appropriate sentiment.

#### RELIGIOUS SERVICE

The Centenary opened officially with a religious service Sunday morning. Rev. Ralph C. Hutchinson, president of Lafayette College emphasized the need of physicians in public life to eradicate the greatest disease of humanity, war. He declared that America can prevent all international war, that we have the strength and position sufficient to the task. Rabbi Joshua L. Liebman followed with emphasis on the common task before religion and medicine in our present world, that of curing soul and body and producing peace. To have no war there must be no conflict within each of us as individuals. Monsignor Fulton J. Sheen's eloquent address brought to a close the opening session. He declared that state controlled medicine would develop when the doctor loses his love of humanity and his desire to serve him in his ills. The clenched fist is the symbol of hate. It must be opened and in the spirit of love the rights of the individual respected. In his closing remarks he listed the attributes of the good physician.

#### ANCILLARY CONFERENCES

During the days preceding the opening of the A.M.A. sessions many organizations representing specialties and special groups met in conference. For example, the Association of Chest Physicians had about 600 in attendance. On Sunday afternoon two conferences of importance convened. One a National Conference of County Medical Society Officers was authorized by the Board of Trustees of the A.M.A. By the method of panel discussion this conference attempted such problems as the relationship of the physician to his medical society, to his hospital, to his patient, and to the public, and the distribution of medical care by prepayment plans, by rural health programs, through the Hill-Burton Act and health centers. One of the panel members was our own executive secretary, Creighton Barker. The Conference was exceedingly well attended and the discussions enthusiastically supported, but by the very magnitude and scope of the subjects under discussion it was apparent that the program committee had been over ambitious in its attempt to cover such a large field.

#### DR. HOWARD PRESIDENT-ELECT OF PRESIDENTS' CONFERENCE

The Third Annual Conference of Presidents and other Officers of State Medical Associations also met Sunday afternoon. This conflict in timing was unfortunate. In the election of officers of this conference for the coming year, Joseph H. Howard of Bridgeport was made president-elect. This is an honor well deserved. Two years ago Dr. Howard's excellent paper on Voluntary Group Health Care Programs provoked nationwide comment. This Conference of Presidents was fortunate in listening to both General Hawley and Senator Taft. Dr. Hawley pulled no punches. He declared that it was the experience of VA that examinations for adjudication of claims for pensions were done better by physicians in full time employ of the government and that the greater part of the outpatient treatment of veterans was accomplished better by private practitioners. His remarks on the fee schedules established in the various states was to the point. He decried the method adopted by some in selecting the highest fees possible in order to get all the traffic could bear. Also he admitted having been taken "for a buggyride" by other states where the VA fee

schedule had been used to force up the Workmen's Compensation fees. The 10 per cent grasping group of physicians can give the whole program a bad reputation. Thirty-eight states have agreements with VA resulting in \$2,500,000 a month being paid to physicians. In many areas physicians are receiving more from the government than from private practice. Declared Dr. Hawley, "I take a rather jaundiced view of acts to jack up the ante." "The clamor in Congress for some regulation of the private practice of medicine may be the result of some of the unfair demands by physicians," he remarked.

Senator Robert A. Taft outlined his bill—S140—for health legislation. He contrasted it with the new Wagner-Murray-Dingell bill, S1320. The latter implies a payroll tax of 4 per cent but does not guarantee that this will pay the total cost. He called attention to the fact that this so-called compulsory health insurance bill is not insurance at all but another tax. Medical care for the indigent has grown up in a haphazard way with gaps here and there. The real problem is of those who cannot pay for catastrophic illness. Many states are unable to come anywhere near meeting the cost of providing medical care for the indigent. The Taft bill provides \$200,000,000 to go to any state which will set up a plan to give free medical care to any who need it by any method it sees fit. It covers 20 per cent of the people, whereas the Wagner-Murray-Dingell bill covers 95 per cent.

#### HOUSE OF DELEGATES

The centenary session of the House of Delegates was marked by the introduction of a large number of resolutions. Work was delayed by the introduction of so many foreign guests but it provided a diversion of great interest. Thomas P. Murdock as chairman of the reference committee on Legislation and Public Relations did an outstanding job. The addresses of the Speaker of the House, the President and the President-elect were all thought provoking. The last mentioned made many valuable suggestions acted on by the House before its adjournment. The issue coming to the forefront at this session was the question of the status of the general practitioner today. Several resolutions were introduced relating to the appointment of physicians to hospital staffs on the basis of specialty board certification; to the policies of the specialty boards in relation to general practice, preceptorships and residences; to the problems of general practice, and to a special scientific session devoted to general practice at the time of

the interim meeting of the House of Delegates. The House passed a resolution encouraging hospitals to establish general practitioner services embodying the statement that "the criterion of whether a physician may be a member of a hospital staff should not be dependent on certification by the various specialty boards or membership in special societies." A special committee was recommended to study the problems of general practice.

A second problem confronting the House of Delegates related to the national emergency medical service. Both the Surgeon General of the Army and the Surgeon General of the Navy made a plea for sufficient medical officers to maintain the armed forces at the necessary level. An army of 1,000,000 men is contemplated. This will call for 6,000 medical officers. The House passed a resolution calling for the creation of a National Emergency Medical Administration within the federal government to care for the carrying out of plans for total mobilization of the medical and allied resources of the nation, to procure and allot medical and allied personnel in case of a national emergency, and to coordinate civil and military medical and allied services in times of threatened or actual national emergency. The need for a continuation of the Committee on National Emergency Medical Service was apparent from the enlightening returns obtained from the postwar questionnaire received from 26,000 physicians who had served in World War II.

The third outstanding problem considered by the House of Delegates was the nursing shortage. It was reported that 33,000 hospital beds are unavailable at the present time due to the shortage of nurses and that this shortage increased more than 40 per cent in 1946 over 1945. The House went on record favoring the training of practical nurses in hospitals registered by the American Medical Association.

During the session a telegraph was received by President Shoulders from Senator Murray attacking the National Physicians Committee and the American Medical Association and calling them collectivists. This telegram had been preceded three days before by an attempt on the part of Senator Murray to release to the press an explanation of the contemplated telegram. The House of Delegates sent a release to the press condemning this telegram and the group sending it and instructed President Shoulders merely to acknowledge the telegram.

A resolution was passed that all fees for medical service be set by and collected by doctors of medi-



one rendering this service, not by hospitals. The practice of accepting rebates was condemned. The employment by the Veterans Administration under Public Law 293 of unqualified professional personnel was condemned. The practice of the Civil Aeronautics Association in lowering the standards of physical examinations of pilots was severely criticized. Legislation now before Congress to improve the medical standards and pay of medical officers in the Armed forces was approved. It was voted to ask the proper councils of the A.M.A., to conduct a study of group practice. \$140 was disapproved and its place approval of \$545 given, provided it is not possible to secure a Secretary of Health in the President's cabinet. The home town medical care of veterans for service connected disabilities was favored. A resolution was passed calling for the supervision of health programs in schools to be under a doctor of medicine. The Board of Trustees was authorized to set up a public relations program and direct the same, following the resignation of Rich associates. It was voted to request the proper authorities to make expenses of postgraduate education deductible from income taxes. The formation of Pan American Medical Association was approved. Rural health councils in all areas where not now set up were authorized and financial aid by the Board of Trustees where necessary is to be given. A Section on Diseases of the Chest was authorized as soon as the necessary changes in the by-laws can be made.

The delegates from Hawaii reported that an attempt had been made through the legislative body of that territory to socialize the practice of medicine. Labor is moving into Hawaii in force. With the aid of the National Physicians Committee the physicians of Hawaii were able to defeat these bills. A resolution was passed congratulating the Hawaii Medical Association and recognizing that a similar situation exists on this continent requiring eternal vigilance against such subversive attacks.

Connecticut's member of the Board of Trustees, James R. Miller, reported on the study being made of the care of the chronically ill and emphasized the importance of this field of medical care.

The Distinguished Service Medal for scientific advancement in the field of medicine today was awarded by the House of Delegates this year to Henry A. Christian, professor emeritus of medicine at Harvard University Medical School. Dr. Christian is well known to the physicians of North America, not only for his work together with Harvey Cush-

ing in establishing the Peter Bent Brigham Hospital as a teaching institution, but also for his accomplishment in the field of pathology. Graduates of Harvard Medical School for the past forty years may well be proud of this honor bestowed upon one of medicine's leaders.

Officers elected for the coming year were Edward L. Bortz of Philadelphia, president; Roscoe L. Senenich of South Bend, Indiana, president-elect; Thomas A. McGoldrick of Brooklyn, vice-president; George F. Lull of Chicago, secretary and general manager; Josiah J. Moore of Chicago, treasurer; Roy W. Fouts of Omaha, speaker of the House; Francis F. Borzell of Philadelphia, vice-speaker. The next annual session will meet in Chicago in 1948. The delegates from Connecticut, Thomas P. Murdock, Creighton Barker and Joseph A. Howard, together with James R. Miller, member of Board of Trustees, were present throughout the sessions.

#### SCIENTIFIC EXHIBITS

The scientific exhibits fully lived up to the occasion of the centennial and afforded a wealth of material for those in attendance. Connecticut was represented by H. M. Marvin of New Haven who in conjunction with Howard B. Sprague of Boston was responsible for an excellent exhibit of the American Heart Association. J. Whitfield Larrabee of Hartford participated in the demonstrations given in the special exhibit on fractures. The two gold medals were awarded for the exhibit on Radio Elements and Mechanism of Congestive Heart Failure by George E. Burch and Paul Reaser of Tulane Medical School, and the exhibit on Tumors of the Adrenal Gland by George F. Cahill and Meyer M. Melicow, Presbyterian Hospital, New York. The historical exhibits of dermatology, chloroform, and occupational diseases were outstanding, likewise the exhibit of the Medical Department of the Army, the Bureau of Medicine and Surgery of the Navy, and the Veterans Administration. Special mention should be made of the excellent motion pictures afford in large numbers. The American Medical Association had a very fine exhibit showing the progress of medicine during its first one hundred years.

#### TECHNICAL EXHIBITS

It would be difficult to pay due credit to the attractiveness and practical value of the technical exhibits. Many wondered who would win the Cadillac automobile offered by White Laboratories. The latest in surgical instruments attracted hundreds.

Smith, Kline & French Laboratories' exhibit of the early American apothecary shop reminded visitors of the corner drugstore of boyhood days, but in addition it displayed many articles of more ancient vintage. The comfortable lounges, the refreshing drinks served by beautiful costumed maidens, the presence of such personalities as Charles C. Thomas, the publisher, all these and many more attractions will long remain a pleasant memory with the thousands of physicians who were fortunate enough to find hotel accommodations at Atlantic City.

#### ART EXHIBIT

This year Connecticut was represented in the exhibit of the American Physicians Art Association by no less than 39 pieces submitted by 18 different physicians. The names follow:

Leo M. Davidoff, New Canaan; Edward G. Deming, West Hartford; Irving S. Dichter, Stamford; S. D. Firestone, Rockville; Walter M. Grossman, Hartford; Robert J. Hansell, Greenwich; Benjamin F. Kitchen, New Haven; Louise D. Larimore, Greenwich; Margaret MacLean, Farmington; J. Nemoitin, Stamford; Charles W. Perkins, Norwalk;

Louis A. Pierson, Meriden; Ernest Rosenthal, Hartford; William Schneider, Rockville; Jerome Selinger, New Canaan; Peter J. Steincrohn, Hartford; Herbert Thoms, New Haven; William W. Wright, Hartford.

To Edward G. Deming went a second prize for his bronze "Battle Winner." Louise Larimore and Herbert Thoms received awards of merit, the former for her water color "Emergency Operation" the latter for his dry point "The Days of Sail." The Art Exhibit was so large this year it fairly bulged at the seams. Much of it was excellent, some rather mediocre.

To the Centennial Committee, of which Dr. Muddock was a member, the profession is deeply indebted. To the officers of the American Medical Association, the officers of each and all of the sections, and to the members of the local committee on arrangements great credit is due for carrying to fruition a stupendous task. The accomplishments of medicine in the United States during the past one hundred years are now a matter of record. The centenary of the American Medical Association has passed into history.

### CONNECTICUT PHYSICIANS ATTENDING A.M.A. CENTENNIAL SESSION\*

#### FAIRFIELD COUNTY

##### Bridgeport

Bogin, Maxwell  
Booe, J. Grady  
Curley, William H.  
Foley, Francis X.  
Gold, James D.  
Kaplan, Leon  
Keegan, Daniel F.  
Lynch, Hubbard  
Massey, Daniel M.  
Ober, Frank T.  
Oster, Kurt A.  
Plukas, Joseph M.  
Quatrano, Joseph C.  
Smith, Joseph J.  
Turchik, Frank  
Yeager, C. F.

##### Danbury

Booth, John D.  
Fox, Robert A.  
Weiner, William

##### Greenwich

Fisher, Joseph G.  
O'Donnell, T. J.

Squier, Raymond  
Swarts, William B.  
Thompson, Sidney A.  
Tinkess, Donald E.  
Vickers, J. L.

##### New Canaan

Hidden, Robert B.

##### Norwalk

Margold, Allen M.

##### South Norwalk

Simon, L. G.  
Stietzel, Eric E.

##### Stamford

Bowman, S. H.  
Chaucer, Norton G.  
Fiske, Madeline  
Gens, John Paul  
McMahon, Frank C.  
Nemoitin, Bernard O.  
Weaver, Bruce S.

##### Westport

Nespor, Robert W.  
Phillips, H. S.  
Solway, R. I. H.

#### Wilton

Knauth, Marjorie

#### HARTFORD COUNTY

##### Bristol

Stevenson, William R.

##### Farmington

Bunnell, Walls W.  
MacLean, Margaret

##### Hartford

Apter, Harry  
Bingham, Charles T.  
Birge, Henry L.  
Bowen, Francis D. T.  
Buck, Burdette J.  
Buckley, Richard C.  
Daly, Charles W.  
Dion, Asa Joseph  
Donovan, Wm. F.  
Ellison, Frederick S.  
Felty, A. R.  
Finesilver, Edward M.  
Geeter, Isidor S.  
Glass, Geo. C.  
Goodell, Robert A.

#### Hastings, Louis P.

Hennessey, James Joseph  
Hepburn, Robert Houghton  
Hepburn, Thomas N.  
Heyman, Joseph  
Hogan, Walter L.  
Jacobson, Charles E.  
Kalin, J. I.  
Kaschmann, Joseph  
Katz, Dewey  
Kendall, Ralph E.  
Klein, Abraham A.  
Kunkel, F. Earle  
Larrabee, John Whitfield  
Levin, Albert N.  
Little, Milton Frederick  
Martin, Stevens J.  
Miller, Harry Bernard  
Miller, James R.  
Mirabile, Charles S.  
Morrissey, Michael J.  
Osborn, Stanley H.  
Pike, Maurice M.  
Priddy, Foster E.  
Roberts, Douglas J.  
Roth, Frank E.  
Schaefer, Abraham M.

\*This includes registration through Wednesday, June 11, 1947



erbin, A. Frederick  
gal, Jacob Bernard  
nith, Wilson Fitch  
helling, Pinckney W.  
eincrohn, Peter J.  
albot, Henry P.  
ovell, Ralph M.  
ershbow, Nathan  
einer, Sylvia  
Veld, Stanley B.  
Whalen, Edward J.  
White, Benjamin V.  
Whiting, Richard C.  
Wright, William W.  
zman, Burnhardt  
zman, Michael S.

*New Britain*  
rnstein, Dwight J.  
ark, Bliss B.  
atteis, Joseph T.  
rbach, Egmont T.  
erakos, Geo. P.  
quillacote, Vincent J.  
White, John Cowles

*Newington*  
ssen, Paul Irving  
lesnick, Sydney

*West Hartford*  
artin, John G.

*Wethersfield*  
arvey, Edward V.  
CTHFIELD COUNTY

*Norfolk*  
irstow, Richard I.  
rsone, Frank D.

*Thomaston*  
ight, Winfield E.

*Torrington*  
dams, Arthur J.

Danaher, Thos. J.  
Garston, Louis E.  
Mitchell, Gerald V.

*Winsted*  
Cornelio, Francis J.

#### MIDDLESEX COUNTY

*Durham*  
Batell, Leo

*Middletown*  
Crampton, Clair Boebo  
Grower, Julius H.  
Harvey, Carl C.  
Tracy, F. Erwin

*Moodus*  
Berwick, Philip

*Portland*  
Fisher, Jessie W.

#### NEW HAVEN COUNTY

*Ansonia*  
Blumenthal, E. J.

*Hamden*  
Slater, Morris

*Meriden*  
Carey, William C.  
Gibson, Cole B.  
Pennington, H. F.  
Pierson, Louis A.  
Solomon, Charles I.  
Wilson, J. Alfred

*New Haven*  
Barker, Creighton  
Berman, Harry L.  
Bretzfelder, Karl B.

Bruckner, William J.  
Chernoff, Hyman M.  
Chia, William L.  
Colwell, Howard S.  
Conway, David F., Jr.  
Cook, Robert J.  
Corradino, Charles L.  
Cutler, Hermann  
DiStasio, Frank  
Eisenhardt, Louise  
Geiger, Arthur J.  
Gettings, James A.  
Glazer, Morris  
Goldman, George  
Greenhouse, Barnett  
Hampton, L. Jennings  
Hsiao-Chien, Chang  
Jaffe, Samuel A.  
Klatskin, Gerald  
Kushlan, Samuel D.  
Lear, Maxwell  
Levy, Daniel F.  
Marvin, H. M.  
Newman, Harry R.  
O'Brasky, George H.  
Oughterson, A. W.  
Pasternak, Maxwell  
Paul, John R.  
Petrelli, Joseph  
Piccolo, Pasquale A.  
Powell, Wilson  
Raynolds, Randolph  
Rogowski, Bernard A.  
Scarbrough, Marvin M.  
Serafin, Peter J.  
Shea, Michael S.  
Silverberg, Samuel J.  
Smirnow, Max R.  
Smith, Norman N.  
Strauss, Maurice J.  
Sullivan, Thomas J.  
Verstandig, Charles C.  
Winters, Sidney

*Seymour*  
Rogol, Oscar

*Wallingford*  
Breck, Charles A.  
Carrozzella, John C.

*Waterbury*  
Bizzozero, Orpheus Joseph  
Brennan, Patrick J.  
Corbett, H. J.  
Foster, John H.  
Freiheit, John M.  
Grillo, William  
James, Mary Latimer  
Jennes, S. W.  
Kelly, LeMoyné Copeland  
Kirschbaum, Edward H.  
Lewicki, Edward  
Ruby, Max H.  
Ruby, Robert J.

#### NEW LONDON COUNTY

*Colchester*  
Schwartz, H. Peter

*New London*  
Ferguson, Helen K.  
Haines, Henry L.  
Ward, Lawrence S.

*Niantic*  
MacLeod, Edith A.

*Taftville*  
Archambault, Henry A.

*Waterford*  
O'Brien, John F.

#### WINDHAM COUNTY

*Danielson*  
Chartier, G. M.

*Putnam*  
Margolick, M.  
Shepard, W. U.

*Willimantic*  
Girouard, J. A.  
Vernon, Sidney

## Panel Discussion on Medical Care

The Connecticut State Medical Society sponsored panel discussion on "Medical Care for All" during the recent 50th annual meeting of the Connecticut State Federation of Women's Clubs at the Hotel Pond, in Hartford. More than 200 members of the Federation attended the discussion. The discussants were James R. Miller, president of the Society; Alfred L. Burgdorf, health officer for the City of Hartford; Creighton Barker, the Society's executive secretary; and Howard S. Colwell, associate clinical professor of medicine, Yale University School of Medicine.

## Maggi Company Entertains

Approximately forty members and guests of the Association of Food Service Directors attended the May meeting of the organization held recently at the New Milford plant of the Maggi Company, Inc. The State Medical Society was represented by Joseph H. Howard of Bridgeport and Cole B. Gibson of Meriden. It was announced that the annual meeting of the directors will be held at the plant of the Reader's Digest Association in Pleasantville, N. Y.



**Joseph H. Howard, M.D.**

Dr. Joseph H. Howard of Bridgeport was named president-elect of the Conference of Presidents and Other Officers of State Medical Associations at the annual meeting of the organization held Sunday, June 8, as a function of the centennial of the American Medical Association, in Atlantic City.

Dr. L. Howard Schriver, of Cincinnati, was elected president of the Conference, and three new members elected to the Executive Committee include Dr. Tate Miller, Dallas, Texas; Dr. W. Andrew Dunten, Cheyenne, Wyoming; and Dr. R. S. Berg-hoff, Chicago.

Dr. Howard will assume office at the next annual meeting of the conference. He is past president of the State Medical Society, and chairman of the Society's Committee to Study Maternal Mortality and Morbidity.

Senator Robert A. Taft, principal speaker at the conference, upheld the Taft-Ball-Parnell bill as a national health measure which would improve medical services for the people while maintaining freedom for the medical profession. He decried the Wagner-Murray-Dingell bill as a threat to freedom through the advancement of federal regulation.

### **New London Health Fair**

Closing after four successful days, the first New London Health Fair of its type was shown to an estimated 7,000 persons, Jack F. Hensley, general chairman of the Fair, reported.

The Health Fair, sponsored by the health committee of the New London Council of Social Agencies and the New London Tuberculosis Committee was held at the State Armory on May 13 through the 16th.

The theme of the Fair, health—its importance and its preservation—was the basis of the 24 booths and exhibits displayed by 19 local public health and welfare agencies.

Organizations having an exhibit at the Fair were the New London Tuberculosis Committee, the New London Medical Society, the American Red Cross, the cancer and venereal disease subcommittees of the health committee, the Waterford, Groton and New London Visiting Nurse Associations, the New London Dental Society, the Girl Scouts, the Diocesan Bureau of Social Service, the Y. M. C. A., the Boy Scouts, the Lions Club, the Elks Club, the New London Fire and Police departments, the Infantile Paralysis Foundation, the Child Welfare Service, the Connecticut Dairy and Food Council, the New London Health Department, the New London Department of Education and the Connecticut State Department of Health.

There was no admission charge to see the Fair nor was there a fee for an agency to have an exhibit at the Armory.

The booths averaged 5 x 10 feet in size however they ranged all the way from 3 x 5 feet to 15 x 30 feet. The displays were built mainly by volunteer workers with the agency staff although there were several booths designed by professional display firms.

Each organization handled the publicity for their particular agency with the chairman of the Fair coordinating the over-all promotion. All of the various publicity media were used, pamphlets, posters, radio, news releases, window displays, trailers in the theatres and a great deal of "word of mouth." One novel promotional stunt was the use of two boy scouts as "sandwich" men advertising the Fair.

Each agency was given one day of the Fair during that time they were given the benefit of the publicity and the opportunity to show motion picture on their particular phase of health work. During this day the organization had volunteer workers at their booth to answer any questions asked by the public.

The New London Tuberculosis Committee held its 12th annual x-ray survey in conjunction with the Fair as it was felt by the Fair planning committee that a "drawing card" was needed to attract the



public to the Armory to see the exhibits and the x-ray program had proved to be an attraction in past years.

When the Fair closed on the 16th, the Tuberculosis Committee had x-rayed 2,300 persons who had come to the Fair. This represents an increase of approximately 700 films over the 1946 figure. No children under 15 years of age were x-rayed unless they were accompanied by an adult or had a note from their family physician requesting an x-ray.

A written report is mailed to each individual who had an x-ray at the Fair regardless of the result of the chest plate. If some type of chest pathology is found, that person is told to see his family physician as soon as possible and the physician is given a report of the radiologist's findings.

A number of "rough" spots were found during the Health Fair but this was to be expected in a survey of this type being held for the first time, however, everyone connected with the Fair felt that it was a definite success and that other Fairs will be held in New London in the future.

### Public Health Association Annual Meeting

Members of the Nursing Section of the Connecticut Public Health Association were advised at the association's recent annual meeting to exercise "good common sense" in the management of chronic illness among aged patients, and to remember that "if too many limitations are placed upon these people, they are sure to violate them."

Further cautioning section members to "treat the patient specifically, and not the disease," Thomas P. Murdock, chief of the medical division, Meriden Hospital, pointed out that constant attention must be directed toward the prevention of injuries to aged patients. Though injuries suffered by these patients as the result of common household accidents "are seldom mentioned in connection with the ills of the aged," he said that their occurrence is frequent enough to represent a definite problem.

The address was part of a panel discussion on "The Chronic Patient." Other speakers included Miss Irma Reeves, associate director of the Visiting Nurse Association, New Haven; and Miss Bessie G. Schless, associate case supervisor, Montefiore Hospital for Chronic Diseases, New York City.

Held in the City Hall Auditorium, Meriden, on May 27, the meeting of the nurse's section opened the all-day conference, which was attended by more than 300 members of the association.

At a meeting of the Sanitation Section, present deficiencies in housing sanitation were discussed by C. E. A. Winslow, professor of public health, emeritus, Yale University School of Medicine.

"The present situation is simply chaotic," Professor Winslow declared, and warned that ancient building codes, divided responsibility among city agencies, and failure to perform routine inspections, are creating serious public health problems.

The desertion of cities by large numbers of people intent on country living, and the decentralization of industry and business are resulting in a fairly steady decline of budget funds for city managements, and consequent difficulties in supporting adequate programs of public health, he pointed out.

Problems in city food sanitation were discussed by Joseph I. Linde, M.D., health officer for the City of New Haven. He cited the operation of the Connecticut Food Institute as an example of the modern educational approach to these problems. Through the institute restaurant personnel are taught how to properly prepare and handle food, Dr. Linde explained, and added that the success of this venture has demonstrated that it is far more effective than complete dependence on sanitary codes and their enforcement.

Other speakers included Neeley Turner, Connecticut State Experiment Station, New Haven; Harold B. Robinson, sanitarian, United States Public Health Service, New York City; and Leslie K. Sherman, Connecticut State Department of Health.

The afternoon session was devoted to a panel discussion on "Public Health in One Basket," led by Professor Ira V. Hiscock, Department of Public Health, Yale University School of Medicine. Discussants included Dr. Vlado Getting, Massachusetts State Commissioner of Health, Boston; Dr. Charles C. Wilson, Department of Public Health, Yale University School of Medicine; Miss Besse B. Randle, director, Division of Public Health Nursing, Nassau County, Department of Health, Mineola, N. Y.; and Mrs. Robert I. Laggren, board member, Middletown District Nursing Association, Middletown.

### Dr. Bayne-Jones Receives New Appointment

Dr. Stanhope Bayne-Jones, professor of bacteriology, Yale University School of Medicine, and director of the Board of Scientific Advisers, Jane Coffin Childs Memorial Fund for Medical Research,

was recently appointed president of the Joint Administrative Board of the New York Hospital-Cornell Medical Center.

The appointment, which will become effective July 1, was announced jointly by Dr. Edmund Ezra Day, president of Cornell, and William Harding Jackson, president of the New York Hospital. These institutions share in the operation and maintenance of the Medical Center, located at 525 East Sixty-Eighth Street.

Dr. Day explained that the new position is that of chief executive of the joint board, which includes representatives of the hospital and the university. He stated that the position has been created to "implement the center's full potentialities for public service," and added that Dr. Bayne-Jones "will be responsible for the formulation of policies and an overall program for the center."

A leader in cancer research and public health, Dr. Bayne-Jones was dean of the Yale School of Medicine from 1935 to 1940. He is a veteran of both world wars and served in the Office of the Surgeon General as Deputy Chief, Preventive Medicine Service, administrator of the Army Epidemiological Board, and director of the United States Typhus Commission, from 1942 to 1946. He received his separation from the military service in the rank of brigadier general, and is still medical consultant to the Secretary of War.

Born fifty-nine years ago in New Orleans, Dr. Bayne-Jones graduated from Yale University in 1910, received his M.D. and M.A. degrees at Johns Hopkins School of Medicine in 1914 and 1917. He holds honorary degrees of M.A. from Yale University and Doctor of Science from the University of Rochester.

His first appointment was that of associate professor of bacteriology at Johns Hopkins, a position which he held until 1924, when he became professor of bacteriology at Rochester School of Medicine. He received his professorship in bacteriology at Yale University School of Medicine in 1932.

Dr. Bayne-Jones entered the first World War in 1917 as a captain in the Medical Corps, serving with the British in Flanders and Italy, and later with the American Expeditionary Force in France. Following the armistice, he was named Sanitary Inspector for the Army of Occupation, in Germany. His military decorations include the Distinguished Service Medal, Silver Star with two oak leaf clusters, United States of America Typhus Commission Medal, Army Com-

mendation Ribbon, British Military Cross, Honorary Commander of the Order of the British Empire, and the French Croix de Guerre.

The announcement of the new appointment followed within several days the presentation to Dr. Bayne-Jones of the Dr. Charles V. Chapin Memorial Award by the City of Providence, R. I., in recognition of his achievements in preventive medicine. The presentation took place at the 136th annual meeting of the Rhode Island Medical Society and marked the second time the Chapin Medal has been presented to a Connecticut physician. In 1945 the medal was awarded to Dr. Francis G. Blake, Sterling professor of medicine, Yale University School of Medicine, and physician-in-chief, New Haven Hospital.

### Danbury Honors Its 50-Year Practitioners

An auspicious meeting of the Danbury Medical Society was held May 28 at the Ridgewood Country Club in Danbury. The occasion was a testimonial dinner in honor of six members of the Society who have completed fifty or more years in the practice of medicine.

Following the dinner which was presided over by Dr. F. B. Woodford, the toastmaster, Dr. Mullins, proceeded with the presentation of individually prepared commemorative medals to each of the men so honored. These medals were constructed of bronze suitably inscribed with the caduceus, the name of the Danbury Medical Society, the date, and on the reverse side the name and number of years of practice of each individual. Each of these men responded with recollections of the years of practice which were interesting, illuminating, and inspirational to all of those in attendance.

The greetings of the State Medical Society were conveyed in person by James R. Miller, president of the Connecticut State Medical Society, who in addition presented information on the recent activities of the State Medical Society.

The meeting was concluded by an address by the Rev. Hugh Shields of Ridgefield. About fifty physicians attended.

The men who were so deserving of this small token of our respect were as follows:

William Thaddeus Bronson, M.D., William Frank Gordon, M.D., Howard Delano Moore, M.D., Homer Franklin Moore, M.D., Paul Ulysses Sunderland, M.D., Frederic William Wersebe, M.D.



## **Rehabilitation Association Addressed by Dr. Canfield**

Approximately 100 members of the Connecticut Rehabilitation Association attended the spring meeting of the organization held in the auditorium of the Southern New England Telephone Company, New Haven, on Friday afternoon, May 23.

The principal speaker, Norton Canfield, associate professor of otolaryngology, Yale University School of Medicine, and chief of audiology for the Veterans Administration, stated that upwards of 50,000 Connecticut residents are in need of treatment for various degrees of deafness. James M. Quinn, association president, announced that Governor James L. McConaughy has accepted an invitation to be honorary chairman of the organization. It was voted at a business session to compile and publish a directory of Connecticut agencies engaged in rehabilitation projects, and to make this list available to all interested groups and individuals.

The meeting authorized the executive committee to select a representative to attend the annual meeting of the National Rehabilitation Association to be held next October in St. Louis.

The organization represents approximately forty Connecticut health and social agencies, and is devoted to the stimulation of programs of guidance, physical restoration, training and job placement for disabled persons. Other officers are Dr. Randall B. Hamrick, Bridgeport, vice-president, and Frederick W. Novis, Hartford, secretary-treasurer.

## **Dr. Arnold Appointed to Physiotherapy Board**

The appointment of H. Bruno Arnold, M.D., of New Haven, as a member of the Connecticut State Board of Examiners for Physiotherapy Technicians was recently announced by Governor James L. McConaughy. Effective July 1, the appointment is for a term of five years.

Other members of the board include Drs. Mildred Couch, Cromwell, whose term will expire July 1; Denis S. O'Connor, New Haven; Charles Edlin, Waterbury; Edward H. Crosby, Hartford; and George G. Fox, Meriden.

Dr. Arnold is director of the Department of Physical Therapy at the Hospital of St. Raphael, New Haven, and a member of the Board of Directors, New Haven Curative Workshop. He graduated from

Yale University in 1932 and received his medical degree at the Yale University School of Medicine in 1926. Following internship at the Newark City Hospital, he spent six months studying diseases of the nervous system and general medicine in European clinics.

A veteran of World War II, he was called to active duty from the Naval Reserve on June, 1940, in the rank of Lieutenant Commander. From September, 1944, to his separation with the rank of Captain in March, 1946, he was head of the Physical Medicine Section of the Bureau of Medicine and Surgery in Washington, D. C. Formerly president of Arnold College, Milford, from 1938 to 1942, he is a member of the American Medical Association, the Congress of Physical Medicine, and state and local medical societies.

## **Distribute Cancer Bulletin**

The State Medical Society and the Connecticut Cancer Society are cooperating in the distribution of one of the most complete bulletins yet compiled on the subject of cancer.

The data included was prepared and published in recent months by the Committee on Cancer of the Illinois State Medical Society. It has been bound in a loose-leaf handbook, so that additional chapters may be added as they become available. Since the supply is limited, the manual is currently being sent to those members of the Society for whom it may have the most immediate interest.

The contents include statistical charts and graphs, and color and x-ray photographs, in addition to the text material. As the introduction indicates, the purpose of the Illinois physicians in publishing the reports is to assist physicians everywhere in discovering cancer in its earliest stages. The study graphically portrays the destructive progress of the disease from a national total of 19,381 deaths in 1900 to 166,848 deaths in 1943.

A discussion on "Examination of the Patient" concerns itself with such problems as family incidence and heredity, predisposition, and patient history. Succeeding chapters deal with early diagnosis of cancer of the digestive tract, the breast, the tongue, larynx, thyroid, broncho-pulmonary tract; early diagnosis of tumors of the brain and spinal column; diagnosis of cancer of the skin, lip, liver, gall bladder, and pancreas; and diagnosis of cancer of the bone.

How the presence of cancer may be more readily diagnosed through use of the laryngoscope, bronchoscope, and esophagoscope is the subject of another chapter, illustrated with color photographs.

The final chapter of the handbook discusses "Early Diagnosis of Carcinoma in the Genitourinary Tract," and "Applied Biopsy in the Early Recognition of Cancer."

### New Head of College of Pharmacy

Professor Harold G. Hewitt, PH.D., Department of Chemistry, University of Buffalo, has been appointed Dean of the College of Pharmacy at the University of Connecticut, effective July 1, it was announced recently.

Professor Hewitt will succeed Dean Henry S. Johnson, head of the College of Pharmacy for twenty-two years, who has requested lighter responsibilities because of delicate health. Dean Johnson will assume new duties the first of July as Professor of Chemistry.

Born in Milwaukee in 1901, Professor Hewitt is a graduate of the University of Wisconsin, and received his degree in philosophy there in 1926. He was assistant to the head of the university's Pharmaceutical Experiment Station in 1923 and 1924. Since 1926 he has been in charge of the Inorganic Chemistry Division at the University of Buffalo. He is president of the Section on Chemistry, American Association of Colleges of Pharmacy, holds membership in a dozen social and scientific fraternities, and is a member of the American Association of University Professors, American Pharmaceutical Association, American Chemical Society, and the American Association for the Advancement of Science.

### General Practitioner's Position in Hospital

The Joint Committee for the Coordination of Medical Activities met at A.M.A. headquarters recently and expressed concern over the growing tendency to exclude the general practitioner from hospital staff privileges. This development is making it impossible for the general practitioner to obtain the advantages of modern hospital facilities for treatment of his patients. The Joint Committee feels that the immediate need is the integration of general practitioners into the hospital staffs throughout the country. To accomplish this the Committee recommended that the Council on Medical Education and

Hospitals of the A.M.A. develop as soon as possible several alternate plans. The establishment of a certifying board for general practice is not thought to be the answer, although the Section on General Practice of Medicine is proposing the formation of such a board and the State of Indiana already has set up such a board.

### Former Hartford Hospital Intern Dies at Saranac

Edward Robinson Baldwin, M.D., a native of Bethel and formerly an intern at the Hartford Hospital, died at Saranac, N. Y., on May 6 at the age of 82. Dr. Baldwin was a noted tuberculosis authority and at one time chief associate of Dr. Trudeau and later his successor as director of the Trudeau Sanatorium at Saranac Lake.

### What the A.M.A. Thinks of Us

Probably the best example of area or joint planning among state medical societies is that carried on by the Council of the New England State Medical Societies. This organization includes Connecticut, Maine, Massachusetts, New Hampshire, Rhode Island, and Vermont, and meets from time to time throughout the year to discuss problems which affect all of the New England State Medical Societies. Expenses of the Council are met through contributions of \$100 from each of the six state societies. Mr. John Farrell of Rhode Island is executive secretary-treasurer for the Council.

### 119 Factory Physicians

*The Hartford Courant* is authority for the statement that information filed with the State Health Board by more than 1,400 Connecticut plants show that 119 physicians are employed in industry in this state, 20 full time and 99 part time. Physicians are employed full time by 12 plants and part time by 80. Of the other plants, 499 list a total of 970 physicians on call and the others use services of physicians in their respective vicinities.

A total of 364 full time registered nurses are employed by 184 plants. Of these 117 plants have one nurse, 33 have two, 16 have three and the others range up to a high of 24 nurses. Part-time nurses are employed by 22 plants and 39 plants employ a total of 55 trained attendants, of whom 50 work full time.



## PUBLIC OPINION IS PUBLIC PROPERTY

Everyone is entitled to his fair share of public opinion. He can enjoy favorable opinions, or become an uncomfortable target for public disfavor.



Most individuals require only a small circle of good public opinion to maintain harmonious relationships. But organizations require conscious and intense development of wide areas of this public domain.



If each individual in an organization recognizes this, and devotes some effort to the creation of favorable opinion beyond his immediate personal needs, then the most powerful device available swings into action for that organization.

Good Opinions Create  
Good Public Relations

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*Fairfield County*, Charles H. Sprague, Bridgeport  
*Hartford County*, Benjamin B. Robbins, Bristol  
*Litchfield County*, W. Bradford Walker, Cornwall  
*Middlesex County*, Richard H. Grant, Cromwell  
*New London County*, Edmund L. Douglass, *Chairman*  
 Groton  
*New Haven County*, Charles T. Flynn, New Haven  
*Tolland County*, Leonard W. Levine, Ellington  
*Windham County*, Brae Rafferty, Willimantic

PUBLIC  
AFFAIRS

## The 1947 Legislature

After weeks of mid-session delay and uncertainty, the 1947 General Assembly raced to a somewhat ludicrous close twenty-four hours before the statutory adjournment date. Whether it accomplished anything good or great will depend upon where opinion is sought.

History has to be searched for a long time back to find a legislature so strongly of one party as the landslide election of last November gave to the Republicans and the minority was so small as to be quite ineffective. Whatever resulted was Republican from start to finish.

At the start everything was thrown off balance by the campaign promise by both parties for a soldiers bonus. One day the statesmen woke up to the realization that the bonus bill had been passed and the Supreme Court, to the surprise of many, had declared it constitutional. Fifty or sixty million dollars, which up to now has been a lot of money for Capitol Hill, had to be found somewhere in addition to millions more of unusual demands. The state tax base has never been broad enough and both parties have shied away from direct taxation such as income or sales taxes except upon luxuries like liquor and cigarettes, or specific purpose taxes as the gasoline levy for highways. There was no choice this year and a selective sales tax of the California model resulted. It will be a rich tax and provide the state with an income never before available. This year's law imposes it for four years only, but tax laws are not easy to change. It may forecast disaster for the Republican party or put it in a strong position for public usefulness. Time will answer.

As might be expected with one party so strongly in control, the session was relatively free from vituperative debate and name calling. Argument over the sales tax brought forth some vigorous words in the Senate and the hearing on the birth control measure produced the usual division of opinion, but

otherwise there was a general feeling of lightheartedness and agreement except over private and local questions.

In the health and welfare fields some real progress appears to have been made. After more than a decade of discussion it was agreed that the state has a problem in the care of the chronically sick and aged and nine hundred thousand dollars was appropriated to start a program for their care. It is a small amount in comparison to what will be needed but great credit is due the Commission of which Dr. Creadick is chairman and Dr. Howard and Dr. Osborn are members, for presenting the case at last in a way to convince the Legislature to recognize the need. Physicians more than any others will note and appreciate the developments in this badly needed human service.

Twenty-five thousand dollars was granted the Health Department to develop health districts, a measure which the Society also supported. It is not enough to produce a broad program of full time health organization for towns but it will make possible experiments in the field and an opportunity to learn how widely the project will be accepted.

State aided voluntary hospitals were given a dollar a day more for the care of state cases which was not the amount sought but it will help cut down the losses these local philanthropies incur in meeting state responsibility.

A new Commission was created to direct the rehabilitation of state institutions and about five million dollars will be provided for that purpose. This act, introduced by Mr. Curtis of Bridgewater, is a new method for determining the needs and supervising expenditures for a number of agencies and its progress will be watched by those interested in maintaining and expanding public institutions.

Recent court decisions moved the Connecticut Medical Examining Board to seek amendment to the Medical Practice Act to make clear the Board's dis-



cretion in endorsing licenses issued by other states. This measure passed without opposition and puts the Board in a better position to operate in the public interest.

A long sought change in the law covering the commitment of persons to hospitals for the mentally ill was passed. The amendment removed the vicious and disregarded requirement of "sudden and violent" and "dangerous" for admission on emergency certificate. Other proposals for examination by qualified or diplomated psychiatrists and the establishment of a state board of psychiatric examiners did not receive favorable consideration.

Funds were provided for a much needed infirmary at the University of Connecticut.

On the negative side a bill that would have established a state blood and plasma service did not arouse the response that was anticipated. The measure was supported by the Society and the American Red Cross but the appropriation asked by the State Health Department appeared to be too large and an unfavorable report was brought in.

None of the regularly recurring proposals for the study of state health insurance or creating a state health insurance system received favorable action.

There were a number of bills to revise the medical phases of the Workmen's Compensation Laws. One particularly would have given injured workmen free choice of physicians and hospitals. On some of these no committee reports came out and no changes were made.

So the 1947 Legislature ran itself out, it may almost be said, tired itself out. It has received and probably will receive more criticism than praise. But it did some good things and conspicuous among them will be the understanding and fairly generous attitude toward the health and welfare of the people and a quiet view of respect for the medical profession.

### **Reciprocity Agreements for Licensing of Natureopaths Eliminated**

Connecticut's link in the chain of reciprocity agreements by which natureopaths have secured licenses to practice in this state has been severed by action of the General Assembly.

Acted upon in the closing days of the session as House Bill 1500, the legislation eliminates Section 2770 of the General Statutes, entitled "Certificate Without Examination." Under this section, the State

Board of Natureopathic Examiners has been empowered to "enter into agreements of reciprocity with a board of natureopathic examiners in any other state whose requirements shall be equal to those of this state."

The effect of the General Assembly's action will be to require all applicants to meet the standards of examination and practice of the Connecticut State Board of Healing Arts as a prerequisite to obtaining licenses from the State Department of Health.

The measure passed by the legislators was supported by State Health Commissioner Stanley H. Osborn as one of several bills aimed at curtailing the issuance of natureopathic licenses on the basis of reciprocity agreements. The only natureopathic legislation to pass both legislative houses, the bill is now awaiting signature by the Governor.

Five other measures were introduced as House Bills 381, 382, 383, and 384. These sought to eliminate obsolete wording in existing statutes insofar as they pertain to procedures in effect prior to 1927, when licenses were issued directly by the Board of Natureopathic Examiners rather than the State Department of Health.

Since 1942 the State Department of Health has issued licenses to natureopaths only upon the advice of the Attorney General or by direct court order. During this period eleven licenses have been issued, and twenty-six have been withheld pending further court action.

Recently a decision of the State Supreme Court required that licenses to practice in Connecticut be issued to James A. Lacerenza, of Stamford, and George A. Phillips, of 131 West 110th Street, New York City. Issuance of the licenses had been contested by Commissioner Osborn on the basis of unsatisfactory reciprocity agreements with South Carolina and Tennessee, the two states in which the applicants claimed previous practice. Last January the Tennessee legislature repealed the statute which had authorized licensing of natureopaths in that state, and invalidated all existing licenses. The boards of two other states, South Carolina and Florida, have for some time exercised reciprocity agreements with the Connecticut Board of Natureopathic Examiners.

In legislative public hearings several months ago, Dr. Osborn testified that candidates failing to pass the examinations of the State Board of Healing Arts had thereafter obtained licenses in South Carolina, and that these were later accepted for certification by the State Board of Natureopathic Examiners. It

is estimated that approximately 75 natureopaths are practicing in this state at the present time.

### Assembly Passes Bills for Care of Chronically Ill and Aged

Legislation appropriating \$900,000 for health programs proposed by the Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm was passed by the General Assembly in the last few days of its 1946-1947 session.

The appropriations include \$600,000 for construction of an institution for aged and indigent victims of chronic illness, \$200,000 for grants to state-aided hospitals caring for such patients, and \$100,000 for similar grants to municipal and county hospitals. Total appropriations represent a reduction of \$100,000 from the \$1,000,000 requested by the commission.

According to Dr. A. Nowell Creadick of New Haven, commission chairman, the first part of the program to be undertaken will be completion of arrangements for the care of a test group of chronically ill and aged male patients at the State Veterans Hospital in Rocky Hill. Inauguration of this part of the program awaits completion of a new wing now being constructed at the institution. Its function will be to operate for the next five years as a study unit to gauge the effectiveness of early treatment of chronic diseases among patients. The commission will seek to develop a similar program for women patients as soon as feasible, it is understood.

The general program outlined by the commission includes two main objectives, (1) the provision of more adequate facilities for the care of patients now crowding state and private hospital wards, and (2) the development of medical research and educational activities aimed toward the prevention of disease among the aged.

The magnitude of the problem is indicated by a commission estimate that Connecticut's present population of persons aged sixty or more is approximately one-quarter million, and is increasing at the rate of 250,000 persons annually. Studies made by the commission indicate that this rate will continue to rise.

While the provision of facilities is in itself a problem of large proportions, the commission states that the most serious obstacle to be faced is that of securing physicians for the medical staffs required

to make the program effective. In contrast to the previous concept of furnishing custodial care to meet the problems of the aged and indigent, it is pointed out that the new program is expected to expand rapidly in the direction of medical care.

Members of the commission include Mrs. Frances Burke Redick, Newington, secretary; Dr. Joseph H. Howard, Bridgeport; and John E. Lamb, Plainville. Ex-officio members are Dr. Stanley H. Osborn, commissioner of health; and Robert J. Smith, commissioner of welfare.

### American Hospital Association Suggests Coordinated Planning

In a brochure of nineteen pages the American Hospital Association emphasizes the necessity for coordinated planning within the federal government as well as between federal and non federal hospitals. It believes that the facts indicate that the Veterans Administration hospital construction program alone cannot be developed to the extent that has been projected without adversely influencing the normal development and maintenance of non federal hospitals.

The Association admits the lack of sufficient buildings and personnel to produce effective service units. Congress has currently appropriated \$772,702,814 for expansion of veterans' hospitals. The Hospital Survey and Construction Act authorizes federal assistance to the states in the amount of \$75,000,000 a year over a five year period, but no part of this has yet been appropriated. Decentralization of the Veterans Administration hospital program would seem to be necessary to plan a suitable hospital construction program on the state level.

A logical answer to the problem would seem to be a medical and hospital care program for low income groups on a federal grants-in-aid basis with a major portion of the expenditures for the low income veteran being made by the federal government utilizing local hospital resources. Under such an arrangement as is suggested above, it would be possible so to plan the expenditure of federal, state and local funds as to expand and supplement present hospital facilities, aiming at care for the population as a whole, on a more economical and effective basis.

On top of all this it now seems to be the intent of Congress to provide hospitalization for all non service connected cases. The Veterans Administration hospital construction program apparently has



been laid out with this in mind. The American Hospital Association calls for a restudy in detail of the Veterans Administration building program beyond 1951 with no further construction authorized pending this study. The Association also believes a committee consisting of hospital authorities from the federal and non federal hospital fields should be appointed to consider the hospital needs of the country, and should be provided with adequate resources for the detailed analysis that will be required.

### Study of Nursing Service Needs

A study to determine the basic needs of nursing service was approved in May by the National Nursing Council. The Carnegie Corporation of New York will provide funds with a grant of \$28,000. The study will be directed by Dr. Esther Lucile Brown, Department of Studies in the Professions, Russell Sage Foundation. It is expected that the study will be completed in six months.

Preceding approval of the study, 19 young professional nurses from hospitals and health centers throughout the country concluded a nine day workshop on April 25. The workshop was devoted to evaluation of present day nursing services and the immediate need for thousands of additional nurses of several types. The approach, however, was on the basis that it is not economically sound to prepare all nurses with the same basic curricula and outline of experience. The workshop examined the variation in abilities of those now called registered nurses and found that present and future demands for different types of nursing service call for a relatively small number of professional women in nursing and for a greater number of nurses prepared at less expense and in a shorter period of time.

### World Health Organization Additions

Twelve nations have ratified the World Health Organization Constitution, according to a report from the WHO Interim Commission. In 1947 the following nations thus far have ratified: Liberia, Ethiopia, Switzerland, Transjordan, Italy, and the Netherlands. Previously China, United Kingdom, Canada, Iran, New Zealand, and Syria had become parties to the Constitution. A total of 26 ratifications by members of the United Nations are required for the WHO to become a specialized agency of UN.

### American Psychiatric Association Elects

At the 103rd annual meeting of the American Psychiatric Association recently held in New York the following elections were made: Fellow, Philip J. Moorad, New Britain; from Member to Fellow, Blake D. Prescott, Hartford; Members, John F. Gray, Hartford; Samuel Susselman, Hartford; Jacob Meshken, Bridgeport; Associate Member to Member, Benjamin H. Gotesfeld, Hartford; Associate Member, Isadore L. Fishbein, Hartford.

### Dr. Henry Sigerist Honored

A dinner in honor of Henry E. Sigerist, M.D., was held at the Plaza Hotel in New York on May 9, 1947. First among the honors and tokens of recognition, a complete set of the *Index Catalogue* was presented to Dr. Sigerist. This set was of particular interest because it had belonged to Dr. Arnold Carl Klebs, also a native of Switzerland and a great admirer of the *Index Catalogue*, who, at his death, left it with his library to Yale University. After long negotiations the bequest finally arrived in this country, but while the book collection with the famous herbals remains in New Haven, the *Index Catalogue* starts a new odyssey back to Switzerland where, in the villa on the shores of Lake Lugano, it will be used in Dr. Sigerist's projected history of medicine.

### Borden Company 90 Years Old

The Borden Company celebrated its 90th anniversary during May of this year. In connection with this anniversary the company distributed an interesting booklet entitled "The Story of Gail Borden." It is a tale of the development of the process of condensing milk by a Yankee pioneer who became one of Texas leading citizens during its struggle for independence from Mexican rule.

Connecticut physicians will be interested to learn that Gail Borden's first condensed milk plant was set up in Wolcottville, now Torrington. This was followed by plants in Burrville and Winsted.

### New Medical School

The Trustees of the University of Miami in Florida have authorized the establishment of a school of medicine to be opened in October. The city of Miami has offered ten acres near the Jackson Memorial Hospital as a site for the new medical school.

## NEWS FROM WASHINGTON

### National Health Program

On May 19 the President submitted to Congress a special message proposing a national health program along the same lines as that proposed in his original message to Congress on November 19, 1945. This program includes a compulsory national health insurance plan. The President declared that: "National health insurance is the most effective single way to meet the Nation's health needs."

Senator Murray (Montana) introduced S1320, to implement the national health program proposed by the President, on May 20.

Meanwhile, on May 21 a Senate Labor and Public Welfare subcommittee, consisting of Senators Smith (New Jersey), chairman; Ball (Minnesota); Donnell (Missouri); Murray (Montana); and Pepper (Florida); commenced hearings on S545, introduced some time ago by Senators Taft (Ohio); Smith (New Jersey); Ball (Minnesota); and Donnell (Missouri), which proposed to coordinate the health functions of the federal government into a single National Health Agency, and would authorize appropriations of approximately \$200 million annually to assist the states in providing general health, hospital and medical services to needy individuals.

These hearings will probably continue into July. It is generally conceded that if any health bill is to be acted upon by the Congress this year, it will be the measure introduced by Senator Taft and his colleagues. There appears to be almost no chance that any bill providing for a broader program or including compulsory national health insurance features will be considered. The sponsors of S545 have attacked the President's proposal as the first step toward "socialized medicine."

However, prospects that this health bill might be passed at least by the Senate this year increased when officials of the American Medical Association, previously opposed to any legislation in this field, appeared before the subcommittee in support of the Taft bill.

### Compromise Bill on S140

On May 28 a compromise bill on S140 was released by Senator Aiken's Senate Committee on Expendi-

tures in the Executive Departments. This bill has three provisions of major importance and concern to the medical profession: (1) Department of Security will be established with a secretary appointed by the President; (2) Appointment of three under-secretaries, one each for education, health and public welfare without professional requirements; (3) "The under-secretary of health shall perform such duties concerning health as may be prescribed by the secretary or required by law." (Quoted from the bill.) No qualifications for the Secretaries are specified which means that the Secretary of the Department of Health might be a layman if the President made such selection.

The Committee explained that most of the witnesses who testified for the bill preferred that qualifications should not be included. In the report, however, the Committee recommends that a physician with administrative ability should be preferred as the Under-Secretary of Health. It may be several weeks before the bill will be discussed on the floor of the Senate. Its companion bill in the House of Representatives, HR573, is with the Committee on Expenditures.

The Senate Committee on Expenditures in the Executive Departments on Thursday, June 5, agreed to report out this bill, as amended. The amendment is extensive. In fact, the bill has been rewritten and copies of the bill, as reported out, will be available.

### New Wagner-Murray-Dingell Bill

The new Wagner-Murray-Dingell bill, S1320—HR3548, is now available and copies may be had on request at the office of the A.M.A. It does not vary greatly from its predecessors, continues the compulsory deduction feature, the involved eligibility clause, and the establishment of a National Advisory Medical Policy Council of sixteen members, appointed by the Federal Security Agency, none of whom must be a physician. It is to be financed by a deduction of three per cent of all wages up to \$3,600 per year. The total may not exceed three and one half per cent of earnings of the first three years or four per cent in the next three years. A new feature is the decentralization of control among local administrative agencies.



# MEDICINE AND THE VETERAN

## COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*  
 EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven  
 JOSEPH N. D'ESOPPO, New Haven

### New Policies of VA Nursing Service

Veterans Administration nursing service, now recognized as the largest in the world, is pioneering in a new concept of nursing practices to give hospitalized American veterans the best possible care.

The four major shifts in policy include:

1. The creation of Professional Standards Boards to evaluate qualifications of nurses for appointment to the nursing service, just as physician boards now evaluate the qualifications for doctors.
2. New regulations revising the promotion of nurses in VA hospitals so that the more proficient may be promoted to the positions in line with their abilities and thereby provide a better service for veterans.
3. Establishment of a rotation policy transferring nurses in isolated VA hospitals to hospitals with teaching units so they may keep abreast of the latest professional techniques and modern nursing practices with a resultant improvement in the nursing service.
4. Complete revision of nursing policies to increase the degree of nursing care given each veteran patient.

The Professional Standards Boards not only will determine whether each applicant meets the basic requirements for appointment, they also will award a grade commensurate with the applicant's professional qualifications. Thus, an outstanding applicant will be placed accordingly.

The boards also will study from time to time the record of each nurse who is serving in the three year probationary period; and, if they find that a nurse is not fully qualified or has not rendered satisfactory services, they will recommend that the nurse be separated.

Other duties of the boards will be: (1) recommendations for promotions, (2) recommendations for disciplinary actions, (3) reinstatement of nurses who have left or were separated from the service

and (4) consideration of all appeals resulting from board actions.

The new regulations for promotions require the service to study the approved proficiency rating of each nurse after each report in order to ascertain the administrative eligibility of the nurse for promotion to a higher grade. Employees found eligible will be ordered to appear before an examining board to determine their professional eligibility for promotion.

Professional promotion boards will be appointed at hospitals, in the thirteen branch offices over the country and in Central Office in Washington, D. C., to determine the professional eligibility of all nurses in the Department of Medicine and Surgery.

Under the new rotation policy that is being planned it is thought that nurses who have served with VA four years or longer may be subject to a two year tour of duty at an isolated hospital.

Nurses eligible for transfer under this policy will be given the opportunity to indicate first, second and third choices from a list of stations submitted to them.

Selection of nurses to be replaced in isolated stations will be made on the basis of the length of their assignments there. It is believed that nurses who have served the longest will be designated for replacement first. An "isolated station" may not be isolated geographically, but it may be isolated from an educational point of view.

The fourth major change in the program—that of revising nursing policies to increase the degree of nursing care given each veteran patient—will enable nurses to devote more time to bedside care by eliminating many of the administrative duties they now perform.

The policy also provides for improved supervision of nurses through the selection of well qualified supervisory personnel in order to assure the best care for veteran patients.

Another phase of this policy provides that nurses

who are especially qualified will be placed in key positions where they will be given an opportunity to develop programs for the improvement of patient care.

The service also will conduct orientation and refresher courses for graduate nurses in the clinical specialties of neuro-psychiatry and tuberculosis so as to improve this care.

Programs will be initiated in the clinical specialties of psychiatric nursing, operating room technique, central supply, orthopedic nursing, medical nursing, and surgical nursing. Advanced programs will be stimulated through extension courses.

The service contemplates the establishment of a cooperative program between the VA and universities whereby the clinical fields in VA may be made available to nurses as a recognized and integral part of an advanced nursing program.

### Central Pathological Laboratory for VA

Establishment of a central laboratory for pathology in Washington, D. C., in cooperation with the Army Institute of Pathology, was announced recently by Veterans Administration.

The laboratory will provide a consultation, review and diagnostic service in pathologic tissues for VA's 126 hospitals and other medical facilities.

In addition, VA pathologists will cooperate with the Army civilian medical societies and others in maintaining a central file of pathologic anatomy and related records for reference, research, training and long range follow-up programs.

The joint laboratory will also provide instruction in pathologic anatomy and histopathologic techniques for VA pathologists and technicians, within the limits of available facilities; conduct research in the pathology of diseases and cooperate with similar research programs of the Army Institute of Pathology, and provide study and review material in the form of study sets, atlases and clinico-pathologic conferences which will be equally valuable to both laboratory and clinical services in their teaching and training programs.

It is planned that branch reference laboratories, to be established in each of VA's thirteen branch offices at a later date, will maintain consultation and training services in pathology for VA hospitals and other medical facilities within their respective areas.

The histopathologic sections of these reference

laboratories will also assist in screening materials being forwarded to the central laboratory in Washington, D. C.

### Bonus Ruled Exempt Federal Income Tax

Bonus payments received by Connecticut veterans definitely will not constitute taxable income, it was announced recently by Internal Revenue Collector Frank W. Kraemer, who said, "The Bureau of Internal Revenue in Washington officially issued its decision that soldiers' bonus payments in Connecticut are non taxable."

"It has been my firm conviction since the passage of the Soldiers' Bonus Act by the State Legislature," Mr. Kraemer stated, "that bonus payments to residents of this state who served in the military or naval forces would not have to be included in gross income by the recipients for Federal income tax purposes."

"However," he added, "inasmuch as the act, as passed by the General Assembly, refers to 'compensation for services,' it was felt, in order to avoid any subsequent controversy on this issue, that a definite ruling from the Commissioner of Internal Revenue should be obtained."

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## THE DOCTOR'S OFFICE

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William E. Furniss, M.D., announces the opening of an office for the practice of obstetrics in Bristol.

Frank Tortora, M.D., announces the reopening of his office for the practice of medicine at 386 Ferry Street, New Haven.

Lawrence G. M. Lydon, M.D., announces his return from military service and the opening of his office for the practice of otolaryngology at 45 Trumbull Street, New Haven.

New Britain Medical Group announces the opening of its offices at 32 Grove Hill, New Britain. Donald A. Bristoll, M.D., obstetrics-gynecology; Bliss B. Clark, M.D., general surgery; Louis W. Daley, M.D., ear-nose-throat; George P. Perakos, M.D., internal medicine-gastroenterology; John C. White, M.D., internal medicine-cardiology; Dwight E. Wilson, M.D., urology. George P. Perakos, M.D., will continue to be located at 300 Main Street until further notice.



INDUSTRIAL HEALTH

COMMITTEE ON INDUSTRIAL HEALTH

C. F. YEAGER, M.D., Chairman, Bridgeport

PRESTON N. BARTON, Bristol  
JAMES H. BIRAM, Hartford  
WALTER M. BRUNET, Bridgeport  
GERALD M. CHARTIER, Danielson  
BERNARD S. DIGNAM, Thompsonville  
JOHN N. GALLIVAN, East Hartford  
ALBERT S. GRAY, Hartford  
MARTIN I. HALL, Bristol

RICHARD J. HINCHEY, Waterbury  
ANDREW J. JACKSON, Waterbury  
ROBERT W. KASCHUB, Groton  
JOHN F. KILGUS, Litchfield  
ROBERT P. KNAPP, Manchester  
ARTHUR B. LANDRY, Hartford  
EUGENE F. MESCHTER, Stamford  
PHILIP J. MOORAD, New Britain

FRANK T. OBERG, Bridgeport  
ISRAEL S. OTIS, Meriden  
JOHN R. PAUL, New Haven  
CRIT PHARRIS, East Hartford  
C. JOHN SATTI, New London  
PAUL W. VESTAL, New Haven  
ELLWOOD WEISE, Bridgeport

Institute of Industrial and Social Medicine

In keeping with its belief that methods of medical practice must keep pace with the changing social structure, and with the demand of the public for more adequate medical service, the New York University College of Medicine will create an Institute of Industrial and Social Medicine, as an important unit of the New York University-Bellevue Medical Center.

This proposed Institute of Industrial and Social Medicine will give the following nine-point program:

1. THE SPECIALIZED TRAINING OF EXPERTS IN INDUSTRIAL MEDICINE

The Institute of Industrial Medicine will offer a graduate program of training, not only to qualified physicians, but to others wishing to specialize in industrial medicine. This program will offer the following opportunities:

- A. To graduates of approved medical schools who have completed one year of internship, a course of instruction lasting one or more years, leading to the degree of Master or Doctor of Industrial Medicine. This course will be made available to qualified physicians from other countries as well as the United States.
- B. To physicians already practicing industrial medicine, refresher courses, or courses in special phases of industrial medicine or in tropical medicine, of one to three months' duration.
- C. To non medical personnel desirous of training in industrial hygiene, social work, personnel management, etc., a course of one year, leading to a degree or certificate in the special field of study.

2. THE EXPANSION OF PRESENT TRAINING METHODS IN THE PROBLEMS OF INDUSTRIAL HEALTH

Already a part of the basic instruction of all students graduating from the New York University College of Medicine, present training will be expanded to include lectures and clinical instruction, supplemented by actual observation in industrial plants, with a view toward emphasizing industrial health as an important part of medical practice, and as a definite medical career.

3. RESEARCH IN INDUSTRIAL TOXICOLOGY

With the developments of new chemical compounds, such as solvents, plastics and synthetic rubber, and the peculiar problems which will arise as the result of new products involving exposure to radiant energy, industrial toxicology is constantly becoming a more important phase of industrial medicine. The Institute will establish and maintain a laboratory of industrial toxicology, and will make available to firms on a cost basis the results of the following studies:

- A. The acute and chronic toxicity of chemical compounds.
- B. Diagnosis and treatment of cases of industrial poisoning.
- C. Study of the conditions in the plant or person leading to poisoning.
- D. Advice as to measures necessary for prevention.

4. RESEARCH IN INDUSTRIAL PHYSIOLOGY AND PSYCHOLOGY

A laboratory of industrial physiology and psychology will be established to explore the reactions of the human body to special conditions of work, and the disturbances of function resulting from un-

favorable conditions. Here will be studied such problems as the effects of heat, moisture, circulation of air, high and low air pressures, and the physical and psychological reactions to fatigue and adjustment to jobs. The laboratory will conduct many of these studies in industrial plants, and will work closely with the Department of Psychiatry in the study of mental health in industry. Consultation with this laboratory will also be at the service of industry on a cost basis.

#### 5. RESEARCH IN TROPICAL MEDICINE

Many industrial concerns have interests and installations in the tropics, and employ both American and native physicians to give health and medical service to native employees. The College of Medicine has a tropical medicine research laboratory which will become an integral part of the Institute, and will be available to industrial concerns for the instruction of physicians in tropical diseases, for consultation, and for the study of specific problems in the tropics.

#### 6. RESEARCH IN SOCIAL MEDICINE

The Medical Center plans a laboratory of social medicine which, together with the Social Service Department, will study the other environmental factors which influence the health of the worker, conditions of housing and nutrition, emotional problems which patients face in achieving recovery, and in preventing recurrence of their symptoms, all of which play such an important role in the problem of absenteeism.

#### 7. STATISTICAL RESEARCH

No Institute, undertaking such a large program in industrial health, and dealing with large numbers of people, can draw reliable conclusions from its work unless it is provided with a statistical service. For this reason, the Institute will establish a statistical laboratory which will be supplied with mechanical equipment for dealing with data on a large scale, thus enabling the Institute, not only to develop research projects and analyze their results, but to make such results generally available to the public.

#### 8. A MODEL PROGRAM OF COMPREHENSIVE MEDICAL CARE AND PREVENTION

The College of Medicine has already organized within its own faculty a group practice unit ready to offer to industrial and commercial concerns a complete health and medical service on a prepayment

basis. This unit will be expanded by the Institute to pursue a three-fold purpose:

A. To serve as a model in comprehensive health and medical care of the highest quality for large industrial concerns, who are interested in setting up similar programs within their own plants. The results in terms of health records, prevention of disability, and cost will be made available to such concerns.

B. To furnish a staff of experts to make surveys of the total health needs of industrial plants, and to make recommendations for the organization and operation of a comprehensive health program, with estimates of cost, space requirements and personnel.

C. To serve as the health and medical department of small industrial concerns, who cannot afford to provide their own full time health programs. The Institute will evolve a system of health supervision, which such firms can afford, and which will be adapted to the specific industry or plant concerned.

#### 9. REHABILITATE INDUSTRY'S DISABLED AND HANDICAPPED, AND GET SICK WORKERS FROM BED TO JOB FASTER

While preventive medicine and care during sickness have been advanced greatly, too little has been done in the third phase of medical care, which takes the patient from the bed to the job. In cooperation with the Institute of Rehabilitation and Physical Medicine—the only one of its kind in the country—business will be given an opportunity to save many dollars in compensation. Moreover, the social and moral satisfactions obtained by the successfully rehabilitated and employed handicapped worker and his family will be great.

### Industrial Physicians Meet in Manchester

"Any sensible individual in industry today must acknowledge the tremendous value of industrial medicine," Henry R. Mallory, executive vice-president and director of Cheney Brothers, Inc., told members of the Society's Committee on Industrial Health at a meeting in the Hartford Club, Wednesday evening, May 28.

While industrial management has no adequate method of measuring the true value of industrial medicine, he declared that its results "in terms of human salvation" are obvious to modern management.

"There has been a tremendous revolution during



the twentieth century in the whole outlook and approach of management in industry," he told the committee, and prophesied continued progress in the field of industrial human relations.

The meeting followed a dinner given by the management of Cheney Brothers, and was the concluding event of a program which started with a tour of the company's Manchester plant early in the afternoon. During the tour members of the committee inspected the plant hospital, observed the weaving and production of textile materials, and attended a demonstration of the testing tower where parachutes made by the company for the military services are tested prior to shipment.

Robert P. Knapp, M.D., physician for the company, and a member of the committee, discussed medical problems of the textile industry following the talk by Mr. Mallory. The industry has no unusual hazards, he said, and explained that the main effort of his medical department is directed toward the maintenance of good employee health through the practice of preventive medicine. The program is accomplished through pre-employment and periodic health examinations, routine chest x-rays, tests for venereal and other diseases, and education in industrial safety, diet, and nutrition.

### Research Award to World's Greatest Physiologist

Recently at Boca Raton, Florida, the man who has been called the world's greatest living physiologist received another international honor. To Dr. Bernardo Alberto Houssay, of Buenos Aires, Argentina, went the first annual Research Award of the American Pharmaceutical Manufacturers' Association "in recognition and appreciation of his illustrious contribution to medical science." The ceremony took place before a group of over 300 gathered at the APMA's 40th annual meeting (April 28-30).

As an added tribute the presentation address was made by the dean of American physiologists, Dr. Anton J. Carlson, of Chicago.

Introducing the "world's two greatest living physiologists," the chairman of the APMA Research Board, Dr. Theodore G. Klumpp (president of Winthrop Chemical Co.) of New York City said that long before the atomic bomb aroused the public imagination, medical discoveries had already awakened people to the part science can play in influencing individual lives.

This awareness of the vast potentialities of science

in shaping the future of our world and ourselves ran like a thread of hope—and warning—through the formal addresses of the opening session.

APMA's president, James L. Rogers (president of Central Pharmacal Co.) of Seymour, Ind., first focused attention on it in his "president's report," when he called for an interchange of scientific information among United Nations and decried the tendency to use science as a political tool.

Dr. Carlson referred to Dr. Houssay as the "scientific beacon at Buenos Aires . . . (which) guides and cheers many workers on the frontiers of biology and medicine in every land." Significant advances in these fields he said could benefit *all* men.

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## O B I T U A R Y

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### Levi Bennett Cochran, M.D.

1867 - 1947

Levi Bennett Cochran was born in Durhamville, New York, in 1867, the son of the Rev. Andrew and Catherine Cochran, his father being pastor in Oneida Castle at the Cochran Memorial Presbyterian Church.

In 1893 Dr. Cochran graduated from the University of Pennsylvania in the Medical Department. After graduation he served as surgeon in a mining camp where he achieved success. In 1897 he was licensed to practice medicine in Connecticut and came to Hartford where he has been in the active practice of his profession until about three years ago when he retired on account of failing health.

For many years he was a consulting physician at the Institute of Living and was a member of the staff of the Hartford Hospital, serving as the chief of a medical service. He was a member of the Hartford Golf Club, the Asylum Avenue Congregational Church, and of the Free and Accepted Masons.

In 1898 he married Louise Bronson of Lowville, New York, who survives him.

Dr. Cochran was a conscientious, careful physician, courageous in his outlook of the future; one who was ready at all times to serve his patients, giving them generously of his strength in their distress and consequently much loved by them.

His place in the medical world will be difficult to fill.

Albert R. Keith, M.D.

## PROCEEDINGS — ANNUAL MEETING HOUSE OF DELEGATES

### New Haven Medical Association, New Haven, Connecticut, April 28, 1947

Annual Meeting of House of Delegates of The Connecticut State Medical Society, held on April 28, 1947, at the New Haven Medical Association, 364 Whitney Avenue, New Haven, Connecticut. The meeting was called to order at 10:10 A. M. by First Vice-President C. Frederick Yeager.

Secretary Barker called the roll and a quorum was declared present.

CHAIRMAN YEAGER: Once again it is my pleasure to open the meeting of the House of Delegates and I am deeply honored.

Many distressing problems have come to the immediate attention of physicians not only in this State but throughout the country during the past year. At the beginning of this year the basic structure of the best system of medicine in the world was being vigorously shaken and it was hardly possible to tell whether or not our present system would survive. The conditions demanded courage and sacrifices from all of us. The public had to know the true facts about present day medicine. Our profession has long been recognized and identified as one which requires hard work, long hours, courage and sacrifice. The challenge was met and it was the combined efforts of the Officer and Members of this Society that made the past year unusually successful.

You will now hear from our president whose untiring efforts and unlimited sacrifices have contributed immeasurably to maintaining and improving our standard of medicine.

Dr. Yeager then introduced President Cole B. Gibson, who read his report.

PRESIDENT GIBSON: We will now proceed with the regular order of business. The next item on the agenda is the report of the Chairman of the Council, Dr. Murdock.

DR. MURDOCK: Mr. President, the report of the Council is published on page 9 of the agenda. There is no supplementary report. I call your attention, however, to paragraph 2. When this report went to press, the committee, as published, had agreed to serve. Following that, Dr. Bissell declined to serve on the committee, and the Council appointed Dr. Fink of Stamford, so that the committee now is composed of Dr. Soltz, chairman. Drs. Carniglia, Cole, Kilgus and Fink. With that correction, Mr. President, I move the adoption of the report as published on page 9 of the agenda.

This was seconded and passed.

PRESIDENT GIBSON: Next is the report of the Treasurer, Dr. Campbell.

DR. CAMPBELL: Mr. President and Members of the House of Delegates: Although the report of the Treasurer is also published on page 9 of the agenda, as this is my farewell appearance in this role, I am going to take the opportunity of reading it, because I think it is worthy of reiteration and emphasis.

I want to take this opportunity, however, of saying if all the world's a stage, I am very happy to have had the opportunity of playing the part of the Treasurer of the Society for this number of years. I am under deep obligation to the members of this Society for the honor which they have conferred upon me for so many years. I appreciate

it, and thank you.

Dr. Campbell read his report and it was accepted as read.

PRESIDENT GIBSON: Next is the report of the Executive Secretary.

Executive Secretary Barker read his report which was accepted.

PRESIDENT GIBSON: Next is the report of the Editor of the JOURNAL, Dr. Weld.

DR. WELD: Mr. President and Members of the House of Delegates: In addition to the report as published in the agenda, I would like merely to call your attention to the fact that this is the first year we have realized a fairly handsome surplus from the activities of the JOURNAL. It is a little over \$2,000. I am not kidding myself that this is going to continue. The year 1946 was the year of the peak of advertising throughout the country, and our JOURNAL profited along with the rest. Changes have taken place in the Cooperative Medical Advertising Bureau so that it is now increasing its business steadily. However, we already have had cancellations which were not unexpected, chiefly from such products as penicillin, which is no longer a necessity for advertising as you may well realize. So that we in the JOURNAL look forward to 1947 as a prosperous year, but not with a surplus to be realized such as we had during this past year. (Applause.)

This report was accepted.

PRESIDENT GIBSON: I will call now for the report of the committee on Medical Education and Licensure.

SECRETARY BARKER: Mr. Chairman, this report is published on page 10. Through an oversight, my name did not appear at the bottom of the report, so I would like to tell you now that I am responsible for it, at Dr. Bartlett's request. I would like to extend this report for just a moment.

I think there are some points here, if you will take time to read the report, which may give you some concern. The Board licensed in one way or another more physicians in 1946, and by far more than had ever been licensed in any previous year. Now, the reasons for this, at least some of the reasons for it, will become clear to you, I am sure; and that is that during the years just preceding, during the war, there was a slowed activity on the part of the board, and so the number that were licensed during 1946 was, in a sense, taking up that slack, and also reflected the unrest, perhaps, of physicians following their discharge from military service.

This state cannot have licensed here every year a number of physicians like this. You wouldn't be able to get around. But I would like to extenuate the circumstances a little bit for you, and this is really what I got up to say. By no means will this large number of physicians who were licensed last year stay in our state, nor is it their intent to stay in our state, I am sure. There are some conditions here that throw us out of balance, with a relatively small number of physicians in comparison to the normal, we say, of Massachusetts. We do have two large centers of post-graduate training, the New Haven Hospital, and now the Hartford



Hospital. Pretty generally speaking, these residents and assistant residents in these hospitals are required to take state licenses. So that out of this number of something over three hundred, it is likely that one hundred, nearly, will fall into that category and probably never remain permanently in our state in competitive practice.

That also applies to the staff of the Newington Veterans' Hospital, where all staff members have been requested to obtain state licenses, although it is not legally required. So don't be too dismayed about this large number. There are some statistical facts here that I think you should understand.

This report was accepted.

There followed the acceptance of several committee reports printed in the agenda.

PRESIDENT GIBSON: I will call for the report of the Committee on Public Policy and Legislation, Dr. Douglass.

DR. DOUGLASS: Mr. President and Members of the House of Delegates: The report of the Committee on Public Policy and Legislation is to be found on page 11, and since I have no additions to make, I move that the report be accepted.

The motion was seconded and passed.

PRESIDENT GIBSON: We will call for the report of the Committee on National Legislation, Dr. Stringfield.

DR. OGILVIE: Dr. Stringfield being absent, the report is printed on page 11 and 12. I know of no further additions to make to the report, and I move it be adopted.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call for the report of the Committee on Hospitals, Dr. Hastings.

DR. HASTINGS: I have no addition to make to this report, except to call your attention to the last paragraph, in which it is stated that the committee has become considerably interested in the nursing situation, particularly in the training of assistants.

There was a recent recommendation by the American Surgical Association, which appeared in one of our recent journals, and I refer particularly to that portion which calls attention to the fact that possibly one of the reasons for the acuteness of the problem may lie in the inattention which the medical profession has shown so far as the nursing training program is concerned. I think all of us feel that it has got somewhat out of hand, that the need of bedside nursing is real. I am sure that it is slowly but certainly coming to a head, and that you will certainly see some changes made in the next year. I believe the medical profession should interest itself in it, because the patients are the sufferers, and they are your patients.

I move the adoption of this report.

The motion was seconded and passed.

PRESIDENT GIBSON: I call now for the report of the Committee on Industrial Health, Dr. Yeager.

Dr. Yeager read his report which was duly accepted.

PRESIDENT GIBSON: I will call now for the report of the Committee on Prepaid Medical Service.

Dr. Miller read his report which was adopted.

PRESIDENT GIBSON: I will call now for the report of the Committee on Public Health.

DR. COLWELL: The report is on page 12. There are no additions. I move the adoption of this report.

The motion was seconded and passed.

PRESIDENT GIBSON: I call now for the report of the Committee on Public Relations, Dr. Burlingame.

DR. BURLINGAME: The report of your committee has been published. It is a tribute to Mr. Burch. I don't see him here at the moment. But I believe that the report which he has written should be published and made available to the entire membership. It will be printed in the JOURNAL, and I do urge upon you the reading of that report. Your committee is relieved, reasonably happy, but not at all satisfied. We look back over the several years that have passed from a complete inertia, almost an antagonism to anything like presenting our case to the public. We believe that some of that still obtains. But quite largely speaking, we believe the membership of the Society is aroused to the fact that just being good and being honest in your purpose is not sufficient in this day of sin and suffering. We not only have to be good, be high-minded, but the public must be aware of that fact.

It was way back in the time of Dr. Locke, I believe, who had some association with the committee with which I am now connected, that he urged the establishment of a full-time person to do public relations work. The field of your committee is one of those nebulous things that it is almost impossible to sit down and say, "Here, we lay on the counter our results." The work of your committee is the intangible things which, however nonchalantly you may take it, are going to influence the destiny of every member of the Society, favorably or unfavorably.

We are extremely fortunate in having Mr. Burch. It has relieved your chairman and his committee very materially from trying to do, on a volunteer basis, that which can only be done on a full time basis. His work is just beginning. It will gather speed.

It is one of these investments which you make in the future. But it does not relieve every member of the Society from the responsibility of being his own Public Relations Officer with his patients. It is awfully hard to find out whether that idea has caught or not. But we do urge upon the Delegates to take back to your county societies the necessity of the doctors waking up to the fact that your committee, your State Society, and Mr. Burch, cannot go very far unless each doctor considers himself a public relations man in dealing with his patients.

In the olden days, when the doctor was close to his patients, and interested himself in the destiny of medicine, we had the best possible public relations. The best public relations begin at home, through an active membership. Without that, all the Mr. Burches in the world will not do the job for us. I think we are making progress. Thank you for your tolerance in listening. (Applause.)

PRESIDENT GIBSON: Thank you very much. The report of the Committee on Public Relations is before you.

DR. GOLD: I move that it be accepted.

The motion was seconded.

PRESIDENT GIBSON: The question is on the adoption of the report. Will you discuss it?

SECRETARY BARKER: I am responsible for Mr. Burch's absence. He is not delinquent. He is working on another job. So please don't feel that it is his oversight. He is just doing something else and he couldn't be here.

The report was then accepted.

PRESIDENT GIBSON: I will call for the report of the Committee on Tumor Study.

DR. MILLER: Dr. McLellan said that he could not be here very well, and he had nothing to add to his report, which is on page 15. I would therefore move its adoption.

The motion was seconded and carried.

PRESIDENT GIBSON: I will call now for the report of the Committee on Honorary Members and Degrees, Dr. Howard.

DR. HOWARD: Mr. President, I believe there are no candidates to be presented to the House for Honorary Degrees.

The report was duly accepted.

PRESIDENT GIBSON: I will now call for the report of the Committee on the Clinical Congress.

DR. THOMS: The report is before you on page 23. I move its adoption.

The motion was duly seconded and passed.

PRESIDENT GIBSON: I will call now for the report of the Board of Trustees of the Building Fund, Dr. Gold.

DR. GOLD: Mr. President and Members of the House of Delegates: I want to call your attention to the amount received and the number of men who have contributed. About a half of the Society have signified any idea of contributing toward the building fund. You will note that the grand total here is \$65,894; in the last report it is about \$66,000, total.

The Secretary's report stated that the insurance which the members of the Society, through their county associations, get at a very reduced rate, after the dues have been paid out of that gain, if the money which they saved, in addition, could be given to the Building Fund for three years, we would have pretty near what we need, if not more than what we need.

After talking with a number of these men on personal solicitation, they say, "What has the Society done for us?" They ask, "What has it done for me?" If any of you are ever asked that question, be sure you put that insurance question to them.

You will find the report on pages 16 and 17. "The Board believes that the interest of the Society will be served if the number of members of the Board is increased from five to ten so that it will be possible to divide the functions of the Board among three sub-committees. The functions of the sub-committees will be:

"(1) To continue solicitation of contributions from individual members.

"(2) To plan and develop a program of memorial contributions.

"(3) To work in close consultation with our architects in further planning, preparation of specifications and construction of the building.

"To this end, the Board of Trustees of the Building Fund recommends to the House of Delegates that the resolution

passed by the House of Delegates at its Annual Meeting on May 25, 1943, be amended so that the Board shall consist of ten members instead of five, two to be appointed each year by the Council and to serve overlapping terms of five years. Mr. President, I move the acceptance of this report and the adoption of the recommendation."

This report together with the recommendations contained therein was duly seconded and passed.

PRESIDENT GIBSON: I call for the report of the committee on Cooperation with the Yale School of Medicine, Dr. Murdock.

DR. MURDOCK: Mr. President and Members of the House or Delegates: The report is on page 17 of the agenda. There is no supplementary report. The committee expects to hold other meetings with the Yale University group, and it hopes to have one meeting before the close of the year, in June. I move the adoption of the report, Mr. President.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call for the report of the Committee to Study the Organization and Objectives of the Society, Dr. Bishop.

DR. BISHOP: Mr. President and Members of the House of Delegates: The report of the committee is published on page 17 of the agenda. There is no supplementary report, other than that I would like to add that this rather tremendous task has been given the committee, and has been met by the committee, in my opinion, with rather extraordinary interest and enthusiasm. The basic spadework necessary to begin the work is in progress. The time that will be occupied to accomplish its eventual purpose is, at the moment, in my judgment, unpredictable. We will have to submit progress reports at the subsequent meetings of the House, but the work will continue. Mr. President, I move the adoption of the report of the committee.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call for the report of the Committee on the Medical Care of Veterans, Dr. Rentsch.

DR. RENTSCH: Mr. President, Members of the House of Delegates: I want to give credit, first, to this committee that worked with me. They were one of the best groups I have ever worked with. Taking a cue from Dr. Barker, while we know the war is said to be over, this job is going to be with us a long time. Taking a cue from Dr. Burlingame, I would like to ask that each member be a public relations committee with this job, because only in that way can we get it across and do a good job.

The committee feels that we made satisfactory progress. There is still much to be done, and as the report which is on page 18 states, we are in the process of formulation, and the committee's duties have been extended to take that in. It says here "Complaint." I don't like that word. We hope we don't have any complaints. But if anybody runs into things that they would like to discuss, or has troubles that they think the committee can help with, we would be glad to help.

I move the adoption of the report.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call now for the report of the Committee on Rural Medical Service, Dr. Gardner.



SECRETARY BARKER: I am sorry that these two reports come so close together, because it seems to me I am giving the performance, but I would like to speak on this report too, in the absence of Dr. Gardner. I hope he is going to be here. The report is published, but there are some additional matters which I think are of good information to you, and it is this: On July 16, coming up, the Society, in a cooperative enterprise with the State University, is to have an all day conference on Rural Medical Service at the University campus. It is the first of these conferences to be held in the eastern part of the United States, and it is being motivated by an experimental point of view somewhat, to see what exploration of this field will bring us, and to stimulate the original interests on the part of many non-medical groups in the rural health program.

You may say that we do not have a rural health program in Connecticut and by standards applied to many other states, we do not have. But nonetheless, there are many questions about care in our rural areas that are worthy of some further considerations, and perhaps improvement.

This conference will be largely one for lay people rather than physicians. There will be practically no clinical material presented, and that which will be presented will be geared to a lay audience rather than to a professional audience.

The planning committee for this conference has already been selected, and we are meeting for our first meeting on May 7. Besides representatives from our own Society, and from the University Extension Service, already we have acceptances from an impressive group of people who are interested in the betterment of rural life, in rural sociology, and in rural health. Some of the organizations that will be represented on this planning committee will be the State Department of Health, the School of Public Health at Yale, the Farm Bureau Federation, the Grange, the Parent-Teachers, the youth movement, the dentists, and a large group of people of that kind. There are about twenty people expected to serve on that committee.

This again is a new kind of an enterprise for the Society to be engaged in. It is an extraneous effort rather than passing the ball around among ourselves, and I am sure there will be an opportunity to come from it a great public service, and an opportunity to impress upon our people, not only in Connecticut, but in New England and eastern New York, that we are alert to this important phase of community life. Certainly, anyone who wants to come from the Society will be most welcome. You will be informed about the program, and the whole business. But it is more an outside effort than within.

We are receiving full cooperation from the State University. Indeed, they welcome the opportunity, not only to engage in this public service, but to engage in it with Society.

PRESIDENT GIBSON: Thank you, Dr. Barker. The report of the Committee on Rural Medical Service is before you.

DR. MILLER: I move it be adopted.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call now for the report of the Committee on Drug Addiction.

DR. MERRIMAN: Mr. President, Members of the House of Delegates: Dr. Foster is out of town. His report is on page 19, and since there are no changes, I move its adoption.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call for the report of the Conference Committee with the Connecticut Pharmaceutical Association, Dr. Salter.

DR. WELD: Mr. President, in Dr. Salter's absence, I would commend him for his excellent report, as I am familiar with the work of the committee. I move the adoption of his report.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call for the report of the Committee on State Blood Donor Service, Dr. Kendall.

SECRETARY BARKER: Mr. Chairman, I again have to rise to perform. I will have to, I think, give you a little history of this enterprise, because it has not been well understood, and perhaps not well enough understood. Relying on the experience of the Red Cross during the war, the Society was asked or conferred with by the Red Cross, as to the possibility of developing a state-wide blood bank. It really was not contemplated as a blood donor service, but a blood bank operated by the public for the public, from which any person, needy or otherwise, might receive without charge, plasma, whole blood, and the various blood fractions which are found useful in therapeutics.

We had a number of conferences with the Red Cross, and it appeared then that the Red Cross Chapters in the state—it was largely led by the New Haven and Hartford County Chapters, and Fairfield too, to a degree, but a somewhat less degree—would be willing to engage in providing blood sources, and that they would provide the mechanism for collecting the blood and carrying it up to the point of processing and distribution.

Then came the activities of this committee, of which Dr. Kendall is the chairman, and Dr. Phillips, who is here, is a member, as to how this should be administered, how the blood should be processed and the program administered and the products distributed. It seemed likely that the most practical way to do it was to engage in a cooperative effort with the State Health Department, and conferences were entered into leading towards such an arrangement. We received understanding and cooperation from the Department of Health.

And then, as inevitable, came the question of money, as to how the expense of this might be met, even though the Red Cross made no charge for providing actually the raw blood. Then we got into a predicament, and I wish you would understand this predicament, as to what happened. There seemed to be a division of opinion as to how much this was going to cost. The people with Red Cross experience had one idea, of "X" thousands of dollars for operation. And the State Health Department, after its review, had another idea which turned out to be about "10 X" thousands of dollars in order to do it. Then, since we were to rely upon public funds, in part, I had a long conversation with one or two others, with our then-Governor, Governor Baldwin, to see if there were funds available in some sort of a contingent fund, that might be immediately put at the disposal of this enterprise. That was not possible, we were finally convinced. It was the governor's opinion that it was not possible to do it. We didn't question his decision at all. He was deeply interested in it, and as a result of his interest,

he asked that the matter be taken up by the Legislative Council, since it would involve the appropriation of public funds by the 1947 General Assembly. And through his request and interest, the Legislative Council did have a public hearing on this subject last fall, and it was very widely attended by interested people, the Red Cross, representatives of this Society, and many others possibly to the extent of 150. The Legislative Council was moved by the evidence presented at that hearing, and made a recommendation in its annual report to the General Assembly, as it is required to do by law, that this enterprise was a reasonable one, and would be in the public interest; and insofar as it was possible, urge the passage of an appropriation to meet the cost of the project.

Then we went back to our original difficulty, as to how much it was going to cost. And finally a measure was introduced into the General Assembly by the Health Department seeking an appropriation so that that department might carry this business on for the next biennium. And it asked for a large sum of money, such a large sum of money that the thing was defeated before they took the measure out of the box. This legislature is not generously inclined, and here was a new enterprise. Most everyone was willing to admit that it was desirable and in the public interest. But under the present 1947 circumstances, it was very clear from the start that the funds would not be forthcoming.

The measure was heard before the Committee on Public Health and Safety, as was proper. This Legislative Committee on Public Health and Safety were again given convincing arguments on the part of all those who appeared, representatives of the Red Cross again, and hospitals, and the Society, and so on, about the same people. The Committee on Public Health and Safety, I think, was moved to agreement that this would be a desirable thing for the people of this state to have, but they also saw the large appropriation in the last paragraph.

Somewhat peculiarly, I think—but I am not critical of the action of the committee—they did not refer it to the committee on appropriations at all. They rejected it forthwith in the Committee on Public Health and Safety.

So there you are. It has taken me quite a long time to tell you that we haven't been anywhere. But I do want you to understand it. I do want you to understand, insofar as it is possible to understand, why the measure did not prevail, and why we are not going to have this blood bank for the next two years, unless some generous philanthropist comes along and endows us with it.

There are some other things. I don't know whether Dr. Miller cares to speak about this or not. I certainly do not wish to without his permission. There are some things that might change this picture somewhat.

This report was duly seconded and passed.

PRESIDENT GIBSON: I will call for the report of the Committee on the Military History of the Society in World War II, Dr. Gilman.

SECRETARY BARKER: I think this is my last appearance. I had hoped that Dr. Gilman would be here to discuss this. This is an important thing, and I think that the committee that has worked diligently on it up to now is somewhat stuck in knowing what to do next. With foresight, I think,

to a degree, we collected biographical and military data on all of our members who were in the service—or at least, we endeavored to—immediately upon their discharge. Those documents, those questionnaires, have been returned pretty well. I think we probably have eighty per cent coverage on them, and we are pegging away at them all the time, so that finally we will have available personal data on all of our members who served in the service. The next thing that is giving the committee concern is what to do with this information. The editorial necessity is a big one. The committee, as individuals, are busy, and they have not yet found a way to edit all of this material. I made a proposal to the committee informally that the Society might feel free and justified in getting the full-time services of a person capable of editing this material, to be in our employ for a short time. I think it would expedite and perhaps improve the character of the material that we will ultimately publish. Just how much that will cost, I do not know, or whether a person is available to do the job, I do not know. I have not made any inquiry to see if there is anyone. I think, however, if Dr. Gilman were here, that he would mention just what I have told you now, that the committee finds itself up against a good deal of a hurdle to get over in editing the material that it has with any sort of promptitude, so that it will be available and in your libraries before we start the compilation of the medical history of the next war.

So if it becomes necessary to make a modest appropriation for this editorial purpose, and it comes before the council, and it is done at the request of the committee—not my request, but the request of the committee—you will understand why this sum has been appropriated, simply to do mechanical work in connection with, editorial mechanical work in connection with this history.

The report of this committee was accepted.

PRESIDENT GIBSON: I will call now for the report of the Committee on School Health and Physical Education, Dr. Hetzel.

DR. HETZEL: Mr. President and Members of the House of Delegates: You have a report on page 21, and I move its adoption.

The motion was seconded and passed.

PRESIDENT GIBSON: I will call now for the report of the Committee to Study Maternal Morbidity and Mortality, Dr. Howard.

DR. HOWARD: Mr. President and Members of the House of Delegates: The report of the Committee to Study Maternal Morbidity and Mortality is published on page 21 of the agenda. Considerable progress has already been made in carrying out the objectives mentioned in that report. Mr. President, I move the adoption of this report.

The motion was seconded and passed.

PRESIDENT GIBSON: There is also a report of the Advisory Committee to the Woman's Auxiliary, Dr. Gilman. His report is published on page 22.

This report was duly accepted.

PRESIDENT GIBSON: The report of the Delegates to the Council of the New England State Medical Societies. This report is published on page 22.



The motion was made, seconded and carried to adopt this report.

PRESIDENT GIBSON: I call now for a report of the Committee representing the Society on the Board of Directors of Connecticut Hospital Service, Dr. Landry. That report also is published on page 22.

This report was duly adopted.

PRESIDENT GIBSON: I will take this opportunity to interrupt the progress, as laid down in your agenda, and take advantage of a very happy situation. We have with us today a delegate from the Medical Society of the State of New York, who is also chairman of the Judicial Council of the American Medical Association. He has very many friends here, and we are very happy that he could be here with us this morning, Dr. Edward Cuniffe. (Applause.)

DR. EDWARD CUNIFFE: Mr. President, Members of the House of Delegates of the Connecticut State Society: I am very happy to come here before this Society, because I have many friends. But I am a little disturbed, in another way, after sitting here this morning and listening to the very learned address of your president, and the eloquence displayed by so many members.

I am very proud to come before this Society, a society that is 155 years of age. That is fifty-five years older than the American Medical Association. Of course, coming from New York, I have to admit that you claim you are older than the New York Society. Of course, we have some questions to ask them, as we do have in New Jersey. They say that they have been in existence for 160 some odd years, and the New York Society has only been in existence for 142 years. But, of course, the members of the New York Society, being very loyal, say that the New Jersey Society was not a state society for a long time after it was organized. I think we will have to have an investigating committee come down here to Connecticut to see about the age of this venerable society.

But I have great respect for the Connecticut Society, for I have a certain awareness of the great contributions that their members are giving throughout these years to the progress of medicine, even in the early days of the pioneering of medical societies, not only in this state, but in other states as well. I have also had an opportunity, in the meeting of the House of Delegates of the American Medical Association to appreciate the good counsel and advice and forward looking suggestions that came from the many distinguished men that you have sent as your representatives to the National organization.

There is a great deal that I would like to say that has been said already. Your President spoke of the high repute of your Society, and of the standing of your members, not here, but throughout the country. I can say that that is safely so.

You know, there is an old story which tells of a rooster going across into an ostrich yard and finding a great big ostrich egg, and rolling it across the road until he came to his own barnyard. Then he called his hens together and he looked at this great big ostrich egg and he said, "Not that I have any fault to find, not that I have any criticism to offer, but I just want to show you what the others are doing." (Laughter.)

That is the way I will go back to my New York Society, and I will just hand them this big egg, lay it in their lap and say, "That is what I learned in Connecticut."

I might just say one other thing. I am impelled to say this, because I have marveled all morning at it. If Tammany Hall is disappearing from New York City, there are other places that are probably much superior in the art of rolling along. (Laughter.)

I thank you very much for this privilege of coming here. Seriously, I am very proud to be here and to have the privilege, under instructions from the Medical Society of the State of New York, to bring you their very friendly greetings, and to wish you, not only a successful meeting, but that you continue to grow in strength and vigor in the courage to uphold the ideals of medicine in the future, as you have in the past. Thank you very much. (Applause.)

PRESIDENT GIBSON: Thank you very much, Dr. Cuniffe. Your presence here this morning has made us very happy. We hope you will stay with us as long as you can throughout the meeting. There won't be quite so much oil tomorrow.

We will pass now to the second phase of the agenda, the recommendations of the Council. We will proceed to the matter of the election of officers and committees.

I will call on the Executive Secretary to present the nominations from the Council.

SECRETARY BARKER: Mr. President and Members of the House of Delegates: Section 3 of Article IX of the By-Laws provides that the Council shall nominate to the House of delegates certain officers and committees for election. Under that Section, the Council makes the following recommendations and nominations: To be President-Elect of the Society, Samuel C. Harvey of New Haven.

The nominations were then closed and the Secretary instructed to cast one ballot for Dr. Harvey.

DR. HARVEY: I feel greatly touched by this. I appreciate the tremendous honor. Moreover, I not only consider it an honor, but a great obligation. And being aware, as I have listened to the session today, how the officers previously have labored, I see that the next two years will be a very busy time for me. Thank you very much for this, and I shall make the best effort I can to live up to those who have done it before. (Applause.)

Then followed the nomination and election of officers for the coming year resulting as follows:

First Vice-President, Alfred Labensky, New London.

Second Vice-President, Francis H. Burke, Rockville.

Treasurer, Cole B. Gibson, Meriden.

Executive Secretary, Creighton Barker, New Haven.

Editor of the JOURNAL, Stanley B. Weld, Hartford.

Delegates to the American Medical Association:

Thomas P. Murdock, Meriden (delegate).

Francis G. Blake, New Haven (alternate).

Additions to the

Program Committee, Maurice T. Root, West Hartford.

Committee on Honorary Members and Degrees, Cole B. Gibson, Meriden.

Committee on Medical Examination and Medical Education, Louis P. Hastings, Hartford.

Committee on Hospital, Harold W. Wellington of New London and Albert W. Snoko of New Haven.

PRESIDENT GIBSON: We will pass now to the recommendations of the Council.

SECRETARY BARKER: Mr. Chairman, the Council wishes to recommend to the House of Delegates the following: "It is recommended to the House of Delegates that the Council be directed to appoint a committee consisting of five members and to name the chairman thereof, to be known as the Committee on the Care of the Chronically Ill. The purpose of this committee is to make a continuing study of the problem of the care of the chronically ill in Connecticut and report annually to the House of Delegates."

I move the adoption of the resolution.

This was duly seconded and passed.

SECRETARY BARKER: In accordance with Article V, Section 1, paragraph 1 of the By-Laws, the Council recommends George B. Darling, Doctor of Public Health, for election to Associate Membership in the Society.

DR. GOLD: I move the adoption of the resolution.

PRESIDENT GIBSON: The question is the adoption of the resolution to elect to Associate Membership in the Society Dr. George B. Darling. Do you wish to know the details of the election to Associate Membership in the Society?

DR. MURDOCK: I think it would be wise, Mr. President.

DR. BARKER: Article V, Section 4, Paragraph 1, states as follows: "Physicians and others interested in the science of medicine and public health who are not licensed to practice medicine in the State of Connecticut may be elected as Associate Members in this Society by a majority vote of the House of Delegates at any regular or special meeting. Candidates for Associate Membership shall be required to file with the Council a formal application for membership, which shall be passed by the Council with recommendation to the House of Delegates. Associate Members shall enjoy all rights and privileges of the society, except that they may not vote or hold elective office. They may be appointed to serve upon committees, present papers before the Society or any of its sessions."

This nomination, Mr. President, was made to the Council, approved by the Council, and Dr. Darling asked to submit a formal application for consideration. Dr. Darling now has the official title of Director of Medical Affairs in Yale University.

A brief paragraph of biography will be of interest to those who are not acquainted with him. He was born in Boston on December 30, 1905. He received a B.S. degree from the Massachusetts Institute of Technology, Doctor of Public Health from the University of Michigan. He has been associated with the Detroit Health Department, with the Kellogg Foundation, National Research Council, National Academy of Sciences, before coming to New Haven.

Mr. Chairman, I move the adoption of the resolution.

The motion was recorded and duly passed and Dr. George B. Darling elected to Associate Membership in the Society.

The Morning Session was recessed at 12:20 P. M.

The Afternoon Session was called to order by President Gibson at 1:35 P. M.

PRESIDENT GIBSON: I am glad at this time that we are able to welcome delegates from other states. I see here Dr. Erickson from Massachusetts.

DR. ERICKSON: Mr. President, on this occasion of the 155th Annual Meeting of the Connecticut State Medical Society, it is my honor and privilege to bring the greetings of the Massachusetts Medical Society, and particularly the greetings of our President, Dwight O'Hara. He particularly wanted me to remind you that the Annual Meeting of the Medical Society of our state takes place in Boston next month. The place is the Hotel Statler headquarters, and the date is May 20, 21 and 22.

I thank you for the privilege of addressing your assembly. (Applause.)

PRESIDENT GIBSON: And Dr. Webber from Maine.

DR. WEBBER: I want to bring you the greetings from the Maine Medical Society at this time, and I am very glad to have the opportunity to be here myself. It is the second time I have been down here, I hope we will be able to have you at the state meeting in Maine this summer. (Applause.)

PRESIDENT GIBSON: Are there delegates from other states here? Well, we are very glad that New York, Maine and Massachusetts are represented.

At this time I should like to present to the House of Delegates a very important member of the central office staff, our Executive Assistant, Dr. Grace Mooney. Dr. Grace Mooney, will you stand and take a bow? (Applause.)

We will now proceed with the order of business.

SECRETARY BARKER: Mr. President, the Council wishes to present a resolution which was not included in the printed agenda. "The Council recommends to the House of Delegates that the action taken by the House at its Special Meeting on December 7, 1944 appropriating \$5,000 as a sum for initiating the project of the Committee on Prepaid Medical Service be rescinded, and that \$3,654.39, the remainder of the sum appropriated, be returned to the general surplus of the Society. The Council further recommends that the sum of \$250 be appropriated for the operation of the committee on Prepaid Medical Service for the remainder of the year 1947, and the sum of \$250 be added to the committee allotments in the 1947 budget of the Society, approved by the House of Delegates on December 30, 1946."

This resolution was adopted.

PRESIDENT GIBSON: Is there further new business?

DR. WALKER: I have a resolution from Litchfield County. May I read it?

PRESIDENT GIBSON: Will you read it, please?

DR. WALKER: "Whereas, the problem of hospitalization is urgent now and will be distressingly difficult for an indefinite period of time; and

"Whereas, there is apparently a definite plan to limit staff membership in hospitals to diplomates of the various Specialty Boards; and

"Whereas, the limiting of staff membership and Heads of Departments of such Staffs in hospitals to such diplomates could tend to injure the best interests of the public and the medical profession as a whole; and



"Whereas, of a total of 180,000 physicians in the United States, approximately only 22,000 are diplomates of all Specialty Boards, and limitation by the hospitals of their facilities to use by these few would work an injustice on other capable doctors and their patients; therefore, be it

"Resolved, that the House of Delegates of the Connecticut Medical Society go on record as favoring the following suggestions in regard to Staff membership in hospitals:

"1. Adequate protection of the rights of all doctors and their patients in obtaining hospitalization to the end that general practitioners, as well as specialists, shall have access to, and use of, hospital facilities.

"2. That the criterion of whether a doctor may be a member of a Staff or Head of a Department shall be his actual ability as a doctor, and not dependent on special Society or Board membership."

I move the adoption of the resolution.

PRESIDENT GIBSON: Is there objection to the consideration of this resolution presented under the head of new business?

The motion was seconded.

PRESIDENT GIBSON: All those in favor of adopting the resolution presented by Dr. Walker will signify in the usual manner. Opposed no. It is a vote and the resolution is adopted.

SECRETARY BARKER: May I ask what the pleasure of the House is in regard to distribution of this resolution?

PRESIDENT GIBSON: Will you comment, Dr. Walker?

DR. DANAHER: I move that the Secretary send a copy of this resolution to all general hospitals in the State of Connecticut.

The motion was seconded.

PRESIDENT GIBSON: Is there further discussion?

DR. MILLER: Since there are three individuals in hospitals who are concerned, it might be well to send a copy of this resolution to all three. I refer to the President of the Staff, the Superintendent of the Hospital, and the Chairman of the Board of Directors or Trustees. There are three individuals, and sometimes a resolution to one doesn't get shown to the other. (Laughter.)

PRESIDENT GIBSON: Dr. Danaher, do you accept that amendment?

DR. DANAHER: I think that is a good idea.

PRESIDENT GIBSON: Will you include that in your motion?

DR. DANAHER: Yes, I will include that in the motion.

This was duly seconded and passed.

Is there further new business?

DR. GOLD: Mr. President, I have a resolution which I have been asked to present.

(Dr. Gold read his remarks, and the resolution which was adopted.)

PRESIDENT GIBSON: Is there further business?

DR. DANAHER: Mr. President, I have a resolution from Litchfield. This resolution was unanimously passed at a meeting of the Litchfield County Medical Association: "Whereas, it has recently come to the attention of the members of this Society that six reputable physicians, all members of the Connecticut State Medical Society, have been

advised by three general hospitals of this State that they may no longer practice in these hospitals, for reasons that have nothing to do with the proper practice of medicine; and

"Whereas, they have not infringed on the codes of these hospitals while pursuing their professions within their walls; and

"Whereas, these hospitals accept public funds raised by general taxes from all the people of this state, regardless of their religious beliefs; and

"Whereas, the action of these hospitals in denying their facilities to these doctors sets a dangerous precedent which may well result in the debarring of all physicians who do not conform, in their entirety, to the religious beliefs of those governing these hospitals; therefore,

"Be It Resolved, that the Litchfield County Medical Association, at its annual meeting held April 22nd, 1947, voices its disapproval of the action taken by these hospitals, and that a copy of this resolution be sent to all general hospitals in the State of Connecticut."

The motion was that the delegates of the Litchfield County Medical Association to the State Medical Society "be instructed to call this resolution to the attention of the House of Delegates at its meeting in New Haven on April 28th and request the House of Delegates to take such action as it may see fit, to the end that properly qualified physicians may not be debarred from practicing their profession in public hospitals because of their religious beliefs."

I move that the House of Delegates voice their disapproval of the action taken by these hospitals, by approving this resolution of the Litchfield County Medical Association.

PRESIDENT GIBSON: Is there objection to this motion which has been introduced under the heading of new business?

DR. WATSON: I notice the last resolution went through without any discussion, so I take it that discussion may come under objection. I never saw this resolution before today. It seems to me that it doesn't carry through. First of all, the motion refers to practicing their profession in public hospitals, and the resolution has to do with hospitals that are not public, so to speak. That is No. 1.

The second question that I would like to ask is: What state funds do these hospitals receive? It was in the paper that they received state grants. If it is meant by state funds, some reimbursements, as all public hospitals and private hospitals get from the state, which is only partial, for the care of the patients, that is one thing. If it is meant to include grants, I object to it.

The third thing is, all hospitals, both public and private, have within their means—and this has been taken to the courts of the United States—whereas men have, coming back from the service, been taken off the staff of hospitals, and I think there is a case that I can cite. I don't know where it is, but it happened in Maryland, where the hospital was the sole judge as to whether or not a man should be a member of its staff. That has been taken to the courts and been upheld in the courts. It seems to me, regardless of religion or anything else, that in hospitals which have certain basic codes, it seems to me they should have the privilege of selecting their staff, as do public hospitals. Any

one of us can quote any number of public hospitals who select their men for certain reasons.

I think it would be a very dangerous thing for this House of Delegates to go on record passing a resolution such as this, because we are overlooking the fundamental rights of hospitals to choose their own members. It isn't a question of why they choose them. The point is, it is their fundamental right to choose them. I object to the resolution.

PRESIDENT GIBSON: Is there other objection to the consideration of this motion which has been put? It should be borne in mind by the House that it will require two-thirds of those present, those accredited members voting in the negative, to fail to consider. Is there further objection? Do you desire the question as to whether or not this business shall be considered? There being no objection, no further objection, it does not appear that two-thirds of the members desire non consideration of this matter. You may proceed. Is there discussion of the motion? Are you ready for the question? Now, Dr. Danaher, would you be good enough to read your motion again?

DR. DANAHER: I move that the delegates of the Connecticut State Medical Society voice their disapproval of the action taken by these hospitals, by passing the resolution offered by the Litchfield County Medical Association.

PRESIDENT GIBSON: In other words, you are presenting the same resolution that was passed at Litchfield County?

DR. DANAHER: Yes.

PRESIDENT GIBSON: Will you so state, so that this may be perfectly clear?

DR. DANAHER: Do you want me to read the resolution?

PRESIDENT GIBSON: No. Will you state what the resolution was from the Litchfield County Medical Association, in order that the House may be perfectly clear on what it is voting. Perhaps it would be just as well that you did, in order that it may be perfectly clear.

DR. DANAHER: You want me to read the whole thing, then.

(The resolution was then re-read.)

DR. DANAHER: I move that the delegates of this Association to the State Medical Society be instructed to call this Resolution to the attention of the House of Delegates at its meeting in New Haven on April 28th and request the House of Delegates to take such action as it may see fit, to the end that properly qualified physicians may not be debarred from practicing their profession in public hospitals because of their religious beliefs.

DR. BARNUM: Mr. President, I would like to ask for information. I would gather that the intent would be served if the five first paragraphs on the paper were included in the resolution, without the sixth; and meantime, that the first line of the fifth paragraph be changed, that the "Connecticut State Medical Society" instead of the Litchfield County Medical Association, at its annual meeting on April 28, instead of the 22nd. Now, if that is what the intention is, that is what I want to know. Then, the other point of information that I think should be cleared up is: What precisely is meant by these public funds? If it is simply compensation for services rendered, it strikes me it has no bearing. If it is in the matter of a grant, as most of the hospitals get, I am not quite sure whether it has bearing or

not. I would like to have some information.

PRESIDENT GIBSON: Dr. Danaher, the first part of that question, would you clarify it?

DR. DANAHER: Which part?

PRESIDENT GIBSON: With reference to paragraph 5.

DR. DANAHER: With reference to paragraph 5. In other words, it should be changed to: "Be it resolved that the Connecticut State Medical Society, at its annual meeting held April 28, 1947, voices its disapproval of the action taken by these hospitals, and that a copy of this resolution be sent to all general hospitals in the State of Connecticut."

PRESIDENT GIBSON: Is that your motion, Dr. Danaher?

DR. DANAHER: Yes.

PRESIDENT GIBSON: Is there any discussion? Would anybody care to answer Dr. Barnum's second question?

DR. WATSON: I am not trying to be obstinate about this. It makes no difference to me. I have my own feelings. But I cannot see the connection between the resolution and the motion. The resolution concerns the expelling of doctors from hospitals. The crux of the motion is that that doctors shall not be debarred from practicing their profession in public hospitals because of their religious beliefs. I think that is a very good motion. But I cannot see the connection between the resolution and the motion. Nobody objects to anybody, no matter what they believe in, practicing in a public hospital. But the motion has to do with private hospitals, so to speak. Where is the connection between the two?

PRESIDENT GIBSON: Dr. Watson, the Chair asked Dr. Danaher to repeat this for that purpose. It was not clear. The question before the house now is the adoption of the resolution as indicated in paragraph 5, in its entirety, substituting for the Litchfield County Association, the Connecticut State Medical Society.

DR. WATSON: You are throwing out the motion, then, is that correct?

PRESIDENT GIBSON: Yes, that was my question to Dr. Danaher a moment ago.

DR. WATSON: I still repeat what I said, that the Board of Directors of a hospital, whether it be public or private, have the right by law, and it has been upheld in the courts, and I object to the resolution on that basis, that they can dismiss, if in their own minds there is a justifiable reason for it. Therefore, I think the resolution is out of order. It has been upheld in the courts.

PRESIDENT GIBSON: Is there further discussion?

DR. HASTINGS: I don't think that other question over there has been answered yet.

PRESIDENT GIBSON: Would any delegates care to comment on the second question raised by Dr. Barnum?

DR. BARNUM: Mr. Chairman, seeing that I get no answer, and am uncertain as to what it is, I would be inclined to suggest the striking out of that third paragraph. I don't know just what it means.

DR. MILLER: Mr. President, I think what is referred to are the public funds which are the grants given at each session of the Legislature to hospitals. They have nothing to do with the service rendered. They are grants of money, public funds, made to hospitals.



PRESIDENT GIBSON: Does that answer your question, Dr. Barnum?

DR. BARNUM: I suspected that was the answer, but I wasn't sure.

PRESIDENT GIBSON: Any further comments?

DR. SPEIGHT: I feel that this resolution will accomplish nothing in a constructive manner. I do feel that it will work against good feeling and goodwill, and offset to a considerable extent the efforts of our committee on Public Relations. I should like, Mr. President, to move that the resolution be tabled.

PRESIDENT GIBSON: The question has already apparently been decided in silence before consideration, Dr. Speight. Under those circumstances, do you move that it be tabled?

DR. SPEIGHT: I believe, Mr. President, a motion to table a resolution is always in order.

PRESIDENT GIBSON: Is there a second to that?

The motion was seconded.

PRESIDENT GIBSON: The motion is to table the resolution. All those in favor signify in the usual manner. Opposed no. The Chair will rule that the no's have it.

Are you ready for the question? The previous question has been called for. All those in favor signify in the usual manner. Opposed no. The resolution is voted for in the affirmative, and is adopted.

Is there further new business?

DR. STORMS: I have a resolution to present from the Hartford County Medical Association to the House of Delegates. "The Board of Directors of the Hartford County Medical Association, being aware of several instances whereby prolonged illness, retirement from practice and other circumstances beyond the control of the member, have made payment of dues a hardship or an injustice, and being aware that while a county association may remit dues, there is no ready method of obtaining relief from state society dues; and feeling that all members should be kept in good standing and be stimulated thereby to retain their interest in and their support of the medical profession, do hereby submit the following resolution to the House of Delegates:

"1. That any member who shall cease active practice and for whom the payment of dues shall constitute a hardship, shall be absolved from such payments as long as he or she shall cease practice.

"2. That the determination of the hardship qualification of such a member shall be the privilege of the Board of Directors of the county association of which the said physician is a member.

"3. That such changes be made in the rules, regulations or by-laws of the State Society as may be required to achieve this result."

PRESIDENT GIBSON: Is there objection to the consideration of this resolution, presented under the heading of new business?

DR. MILLER: Mr. President, that involves to a considerable extent changes in the by-laws. It is unworkable in some of its details, in that not every county medical association has a Board of Directors. I would move you, sir, that this be referred to the Council, for report at the next meeting of the House of Delegates.

DR. BARNUM: Second the motion.

DR. GOLD: Mr. Chairman, I thought there was a means before the Society that anybody from any county association who was unable to pay his dues, if he would report by his councilor to the council, then that man could receive relief from the O. C. Smith Fund, which pays the dues of members who are unable to pay them themselves. As I understood that O. C. Smith Fund, it was given for that very purpose. For quite a good many years, it was used when I was on the Council. It seems to me as though this resolution has not taken cognizance of what is already on the books of the Society.

PRESIDENT GIBSON: Dr. Barker, will you comment on this?

SECRETARY BARKER: Paragraph 4, Section 1, Article XI of the by-laws, already provides as follows: "The dues of any member may be remitted by a majority vote of the House of Delegates." What Dr. Gold has said relative to the O. C. Smith Fund is quite true. There is a fund in the Society, the income of which can be used to pay the dues of members who otherwise are found incapable of paying their dues for themselves. The procedure for that is for the councilor from a county association to bring to a meeting of the council—it is done repeatedly, year after year—a recommendation from his county association that the dues of Dr. John Doe be paid from the O. C. Smith Fund for the next ensuing year. It has to be done each year. That is a little cumbersome. But nonetheless, that is the way it is done.

I have, in my experience on the council, never known the council to decline to follow the recommendation of a councilor in this connection. Beyond that is this provision in our by-laws which has existed forever, I guess. In other words, it is quite possible for this House of Delegates to remit by a majority vote the dues of any member for any reason, providing it chooses to so move.

The third comment that I would make—and please believe that this is all made without prejudice, only seeking the proper way to accomplish the purpose which we have in mind—the proposal made in the Hartford County resolution would, as Dr. Miller points out, require a change in our by-laws. And in order to accomplish that, such change in the by-laws would have to be published with the call of the meeting before it would be proper to vote on it. I would like to ask, if I might, or be permitted to, a question in this regard, as to why this paragraph which I have quoted does not cover the circumstances of this nature as they might arise.

I realize there is a certain shortcoming in this, and that is that it would have this much of publicity, that a motion would have to be brought before this House to remit the dues of a member, and it might possibly result in some embarrassment.

PRESIDENT GIBSON: Dr. Storms, will you comment further?

DR. STORMS: Mr. Chairman, we have been faced with this problem in our county for the last two years, in particular regard to one individual. But other instances have recently arisen, particularly with men who have previously been in practice, and have returned to a hospital residency, where they find carrying on the payment of dues to be somewhat of a hardship. There are others who are leaving or con-

templating leaving their practice to go into a specialty, and we have just felt that we wanted some sort of an understanding as to how to handle the payment of dues from such members.

DR. HASTINGS: May I comment on this?

(Dr. Hastings was granted the floor on vote of the House.)

This resolution was brought by the County Association, not only because of one or two specific instances, but we felt that it went a little bit beyond that. I think our most serious objection to bringing the name of a certain individual whom we wish dues to be remitted on right now before this House of Delegates is, as Dr. Barker expressed, occasionally it is objectionable publicity. I think it is a real objection.

Every one of you, in your own county, from time to time, has some respected member of the profession, and you don't wish to come into a House of Delegates and say why you want his dues remitted, but you, as individuals in your county, know it is a worthy project.

Secondly, aside from residencies that Dr. Storms spoke about, I think that is somewhat of a temporary situation, following the war. But since the chairman of the Public Relations Committee is also a member of our county, we have come to realize that in this day and age every individual in the population that you can have who is interested in and willing to support the medical profession is an advantage.

Now, physicians do retire from practice. They are still able-bodied citizens, some of them in a position to do us much more good than they were as practicing physicians. We feel that any individual who has practiced medicine in this state, and ceases to do so, should still be a member in good standing of the state and county medical associations. You may remove his right to vote, you may put restrictions on him, if you please, but we think he still should be a member. And yet many times he is not in a position to pay dues.

Now, you aren't remitting very much, because it doesn't cost the county association anything to carry him. I don't know what enormous sum it is, but it is a relatively large sum that the county pays to the state each year. But the state isn't losing much, because I understand—and this question might be answered—how much of these dues are passed on to the National Organization? But you have retained an individual who is interested in and will continue to support the medical profession. We really think it is worthwhile. This is a long term project. We are not interested in any individual at this moment. We are perfectly willing that this go to the Council. We know that it is going to imply changes in our by-laws. We know that it is going to take time. But we think it is something that should be done. I don't think the medical profession can afford to lose a single member of its organization. Thank you.

DR. SOLTZ: I don't know whether this discussion is pertinent under this resolution, but in the New London County Medical Association, we have, according to the Connecticut State Medical Society by-laws, a provision that when a member is in practice for fifteen consecutive years, and has attained the age of sixty-eight, or he is seventy years of age—I think it is seventy years of age, and fifteen years of con-

secutive practice, or he has reached the age—I don't know how it is, but it is seventy or sixty-eight, a certain age anyway—but he must apply for that exemption of dues. That does create a lot of peevishness among the men who are eligible for exemption, and not only creates a peevishness with the man who is eligible for exemption, but most of the time men who are eligible for exemption have sons in practice and they get very much peeved.

Now, I can understand, when the dues of the State Society was \$3 or \$4 a year in the past, where we couldn't afford to make many exemptions in the payment of dues. But now, when the dues to the Society are \$20 a year, and most men are twenty-five and twenty-six, and are going to pay dues for many, many years, we can be very gracious about putting men on that basis. I think it would certainly be in the interests of better relations, if a man would automatically be placed on a tax exempt basis when he is entitled to it, not that he begs for it. They won't fight with the state office, but they will tell their county secretary a lot of things that are unpleasant, and so they are peeved. I think it ought to be changed along that line.

PRESIDENT GIBSON: Since the resolution contains a matter that would require amendment, the motion to refer to the Council is in order. Will you discuss that motion?

DR. MILLER: Mr. President, if I might be permitted to change that motion, to refer it to Dr. Bishop's committee. It seems to me that his committee on the study of changes, if any, that should be made in the structure of the Society, would be the proper committee to consider this. This is part and parcel of our internal changes. If I might be permitted, I would like to change the motion to refer it to the committee—whatever it is called.

PRESIDENT GIBSON: Operation and objectives.

DR. MILLER: Operation and objectives of the Connecticut State Medical Society.

The motion was seconded.

DR. HASTINGS: If I may discuss that again, I object. While it certainly is, by title, a proper committee, that committee has got a stupendous job. And with all respect to the committee, God only knows when these changes are going to be made in the organization of our Society. I still think that it is a matter for the Council, and that something should be done about it before our semi-annual meeting. I don't believe that if it goes into this committee, it will come out in time for that, because there are many more important things which this committee has got to bring out before they can touch this.

DR. THOMS: I don't see why this can't be settled, at least for the time being, until such a committee might study this question, by the councilor from Hartford County bringing in a name, or such names as the Hartford County Association wishes to have brought in, for relief from the O. C. Smith Fund.

DR. SUNDQUIST: I am a member of the Board of Directors of the Hartford County Association. I just want to add my small voice to what has already been said. We have a case, and I should personally not like to see this man's brought before this body. I believe it will cause humiliation. If it were me, I wouldn't want it done.



DR. THOMS: It has been done many times before. All the councilor does is to bring the name in before the council, and the council makes the decision. Nobody knows anything about it.

The motion on the referral of this matter to the committee on Operation and Objectives of the Society was lost and a motion then made, seconded and carried that this matter be referred to the Council.

Following several announcements the meeting of the House of Delegates was then adjourned at 2:25 P. M.

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## 6,959 Were Added to U. S. Physician Ranks in 1946

There were 6,959 additions to the medical profession in 1946, according to data presented in the 45th annual compilation of medical licensure and allied statistics by the Council on Medical Education and Hospitals of the American Medical Association and published in the May 17 issue of *The Journal of the American Medical Association*.

"The number of physicians removed by death in the United States, possessions and territories, and those physicians temporarily located in a foreign country in the same period was 3,358," the *Journal* says, adding: "Thus the physician population in the United States was increased by 3,601."

During the year 1946 there were 16,129 licenses to practice medicine issued by the medical examining boards of the 48 states, the District of Columbia, Alaska, Hawaii, Puerto Rico and the Virgin Islands. Of the 16,129 licenses issued, 6,559 were granted after examination and 9,570 by reciprocity and endorsement of state licenses or the certificate of the National Board of Medical Examiners. These figures represent an unprecedented increase over all previous years in both groups.

The greatest number of licenses during the last calendar year were issued in California, 2,045. Both New York and Illinois licensed more than 1,000. Five other states registered over 500; Michigan, New Jersey, Ohio, Pennsylvania and Texas. No state licensed fewer than 30. Comparison of like data presented for the year 1945 indicates an increase in all but three states: Arkansas, Indiana and Tennessee. The increase was spectacular not only in certain states with large urban populations but also in some rural states.

While the more pronounced increase was evident in the group licensed without examination, the group

who were registered after written examination was more than 1,000 greater than in 1945. These figures apparently reflect mainly the migration of veteran medical officers who are not returning to their original state of practice and those medical officers representing recent graduates who were licensed prior to entry on active duty with the armed forces but returned to a new state. Previous compilations indicated that the accelerated program in medical schools (July 1, 1942 to July 1, 1945) produced 20,662 physicians in this three year cycle, while in the four years 1942 to 1945 inclusive 35,821 physicians received licenses. The graduation of one extra class under the accelerated program and the slight increase in enrollment in all medical schools, while intended primarily for the production of additional physicians to aid in the care of the armed forces, is now probably providing a greater physician-civilian population ratio in the country generally.

The greatest number of graduates of any one school examined was 348, representing the University of Illinois College of Medicine, 281 of whom were examined in Illinois and 67 in 18 other states. Graduates of the University of Pennsylvania were examined in the greatest number of states—30. Northwestern alumni were tested in 29 states and Harvard Medical School in 28 states.

Thirteen approved schools in the United States had no failures before medical licensing boards, 35 less than five per cent and 14 between five and 10 per cent.

Altogether there were 7,605 candidates who appeared before medical examining boards in 1946, of whom 6,853 passed and 752, or 9.9 per cent, failed. The number tested exceeded the 1945 figure by 1,015. The greatest percentage of failures represented two groups—foreign schools and unapproved schools.

Increases in the physician population arranged in nine geographic divisions of the United States show that the East North Central and Middle Atlantic group of states added the greatest number, 1,521 and 1,460 respectively. More than 500 were added in five other groups—New England 620, West North Central 770, South Atlantic 888, West South Central 580 and Pacific 606. The East South Central States added 318, the Mountain states 144 and the territories and possessions 52. Alaska did not add a single physician to the medical profession last year in this compilation of first licenses.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, MRS. ROBERT J. COOK, New Haven  
*President-Elect*, MRS. HAROLD W. WELLINGTON, New London  
*First Vice-President*, MRS. CHARLES W. GOFF, West Hartford  
*Second Vice-President*, MRS. JAMES DOUGLAS GOLD, Bridgeport

*Recording Secretary*, MRS. F. ERWIN TRACY, Middletown  
*Corresponding Secretary*, MRS. EDWIN R. CONNORS, Bridgeport  
*Treasurer*, MRS. FRANK DiSTASIO, New Haven

## THE DOCTOR'S WIFE

### "The Acolyte of Medicine"

WILLIAM B. TERHUNE, M.D., *New Canaan*

**F**OOLS step in where angels fear to tread—one man at the mercy of many strong women, and yet, confident of your mercy, like Daniel, I am unafraid. This subject has been chosen for several reasons. One is that I like doctors' wives and wish to tell them so. Secondly, I hope that this discussion may stimulate an expression of your ideas and add to our fund of information concerning the doctor's wife. Therefore, let us consider this a seminar for the more or less free exchange of our ideas.

To begin with, it seems only fair to explain to young women who contemplate entering medicine by way of marriage, what they may expect and what is expected of them. Then we might discuss the psychological characteristics of the doctor. And lastly, I shall venture some suggestions which I hope may assist you in the unheralded performance of a difficult, and yet most rewarding, life's work.

I would advise that only strong, courageous, intelligent women, endowed with a sense of humor, marry doctors. They can be assured of a life devoted to the service of others, which is a job for mature personalities. Theirs will be a life of adventure, comparable to driving a spirited tandem—in this instance consisting of the doctor and the public, both eccentric, unpredictable, and with a tendency to bolt when the reins are slackened. It is to the credit of the medical profession that their wives usually respect, admire and love their husbands. For the practice of medicine is a hard task-master; it develops the best in human character and favorably affects all who are encompassed by it. They are ennobled by the pursuit of its aims and enriched by its unselfish ethics. That is why wives are enthusiastic disciples of the profession, even though doctors are

exacting task-masters and often are hard to live with.

Before proceeding with a specific discussion of the topic of the evening, it might be well to consider, as an introduction to it, what, in general, people may expect of life.

To each of us, living is an individual experience. We seldom realize that the life history of an individual is frequently only a repetition of the history of all human beings. Just as a perceptive, integrated, personality is helped by knowledge of his own personal reaction pattern, similarly, knowledge of the usual or general patterns of human life help to orient one as to the expected developments which take place in her own life. From the standpoint of psychological comprehension it could be stated that the *seven ages of man* are as follows:

1. *The Period of Parental Dominance*—lasting, roughly, from birth to the age of fifteen. During this time the individual is under the control of adults and at the mercy of her environment. During this period obedience is a virtue and the value of initiative somewhat discounted.

2. *Adolescence*—from fifteen to twenty-two. A transition time when the growth of independence is in conflict with previously recognized authority, complicated by childish tendencies to remain dependent.

3. *The Phase of Adult Experimentation*. This is a formative period, when the individual should be acquiring some knowledge for herself as to what the world and its inhabitants are like, in an attempt to find one's life work—approximately from the age of twenty-two to thirty-two. This is the period of



learning by the painful and costly process of trial and error, since as a result of inexperience there are likely to be many failures. The young adult has the opportunity of trying first one thing and then another until he or she falls into an appropriate niche. During this time one must learn not to be too discouraged by temporary failures.

4. *The Period of Acquisition*—from the age of thirty-five to forty-five. Devoted to making a place for one's self in the world. Acquiring children, home, worldly possessions, position, firm friends, and a lasting philosophy of life. If during this period a person loses something she values, she is usually able to replace it.

5. *The Peak of Attainment*—including the ten years between forty-five and fifty-five. At this point we hold and use what we have gathered. If we lose something we value it can seldom be replaced. It is a good time if in the past we have planned well and worked hard.

6. *The Age of Substitution*—from fifty-five to sixty-five. At this time many compromises must be made with life. Experience and skill must replace strength. We must be willing to relinquish gracefully much of that which we have gathered—having tried to find happiness through a material life we must gladly substitute spiritual values.

7. *Old Age*—from sixty-five on. Rightly the "harvest" period of a well spent life. Like reviewing a satisfactory round of golf, stroke by stroke, with many pleasant reminiscences. Keep in mind that older people have a purpose in life—to counsel, stimulate and encourage youth.

This rough outline indicates in a general way what everyone may expect. However, each profession has its individual problems and opportunities and we shall consider those which specifically concern women who are married to physicians. We shall attempt to do this by first describing the characteristics which doctors have in common and outlining the type of life which most of them lead. In other words, what should a woman expect of a doctor husband? This discussion will of necessity deal with generalities. After that you are on your own.

Physicians are above average intelligence. Being quick-witted, they are slightly intolerant to slow minded people. They are individualists who want their own way even a little more than do other men. They are very sensitive and are inclined to be egoists, since many of them have a deep sense of

inferiority and insecurity. They are dedicated to their profession and the welfare of their patients, which interests they place above all others, even wife, home, children, money, social life, position and their own welfare. Therefore, they are not particularly good team mates except in medical undertakings. They have a life of their own, mostly among their medical confreres, and while they tolerate, try to understand and, to some extent, take part in the activities and interests of non-medical people, they frequently do not have a very high regard for such extra-medical, non-scientific activities and interests—all of which often makes for a certain amount of narrowness and rigidity. They are inclined to be lonely people except for their friendships with other doctors and their own wives, but only the latter if their wives make an unusual effort to be friends with them. They are honest, conscientious; usually men of high integrity, who will not tolerate people who cut ethical corners. They have unusually high standards of accuracy, cleanliness, neatness and straight thinking. Their life has taught them to take it on the chin with a smile and fundamentally they have little respect for anyone who does not do this. They make few excuses themselves and expect none from their associates. In general they are virile, dynamic men with initiative. They are difficult, responsible, responsive, and dependable people who are easy to get along with only if they are handled properly.

Their lives are hard, their days are long, their responsibilities, particularly as they get older, are almost greater than any one person should be asked to carry, and, being individualists they are not very good at delegating responsibility. Most of them earn a reasonably good living but their lack of interest in financial matters mitigates against wise management of their financial affairs. Physicians must of necessity present a calm, optimistic, cheerful front to their patients and patient's relatives. Throughout a long day they act a part for the good of humanity; once off the professional stage and in their homes, they seek quiet and peace, free of the galling human eccentricities to which they have been subjected all day. Theirs is in general a discouraging life, for they know that death, disease, and ignorance constantly threaten to nullify their best efforts. More than all other men they must learn to accept defeat daily, and to face tomorrow undismayed. It is not strange that in the quiet of their homes, when they let down, they may appear somewhat pessimistic, moody and

even irritable. Fatigue, both physical and emotional, is a doctor's greatest personal enemy; all are subject to it, but some more than others. His wife's greatest opportunity is to prevent, ameliorate and cure this fatigue—not by urging him to do less, not by making him sorry for himself, but by standing between him and the unthinking public, as well as by bringing him love and understanding, both in almost super-human amounts.

With these, the doctor's personal characteristics, aims and way of life, you are by now familiar. You, too, are dedicated to the purposes, ethics and philosophy of medicine, although many of you entered this way of life without knowing the magnitude of your undertaking, but, having once discovered it, you like it. No other life will ever satisfy you so completely. You would not willingly relinquish this way of living—your unique part in serving humanity. You must like it, considering how much you stand for. It is my opinion that as a group you are the most devoted wives on earth.

What are the characteristics which a woman should possess or develop if she is to do this job successfully? These will differ somewhat, depending on the type of work her husband does and the environment in which she lives.

1. It is self-evident that she must be intelligent, a person of sound integrity, possess good judgment, perception, deep understanding, sympathy, a quiet sense of humor, never failing tactfulness, and the ability to keep her mouth shut, even at home.

2. She needs to be a friendly, warm, outgoing person, who genuinely loves people, since she of necessity is in close contact with the doctor's patients and his work. She is actually an adopted member of the medical profession and must, therefore, live up to its ethics and ideals. Her attitude will reflect either favorably or unfavorably on both her husband and the profession. Friendliness, interest in people, together with a sincere belief in them, are essential in the practice of medicine.

3. She must have social ease and grace—that is, she must be able to get along fairly comfortably with groups of people and individuals—that *she may be able to make them feel more comfortable*. However, she should not be too interested in "society" as such. Just as a doctor should not be involved in business if he is to have any standing in his profession, so his wife should not strive for social position, leadership in causes, or other competitive worldly distinction. She may write, draw, paint, or be inter-

ested in music. Nearly every woman has one or more unrecognized talent which, if developed, would enrich her life. The public looks on doctors and their wives as public servants and rightly expects them to have too much good judgment to be interested in the worthless gee-gaws of social prominence. It is just as well if their names seldom appear in the society news.

4. She must be a well rounded person with intellectual interest. In most instances their husbands have such interests, as do their husband's friends and their wives. The world expects them to appear to be intelligent, well read, straight thinking women. They need interests outside their homes, lasting ones, because otherwise they will be lonely or pathologically wrapped up in their children. They should be interested in the science and the practice of medicine. Their husbands should keep them informed of advances in his profession as an aid to fostering that interest. As a means of keeping abreast of medical progress, the doctor's wife should read *Hygiea* each week. The public is so interested in medicine and lay magazines are so full of pseudo-medical knowledge, that it is wise for the doctor's wife to be accurately informed. However, she should carefully refrain from discussing these matters with friends. She knows all about it, it is interesting but further discussion is unwise. The love of the morbid causes lay people to dwell on such things. The doctor's wife should not try to discuss medical matters with her husband. It is impossible for him to give her a medical education. Her medical knowledge is made up of half facts at best. If she starts giving her opinion about medical matters there may be one of two unfortunate outcomes—he either gets irritated at her presumptuous ignorance, or because he is accustomed to being influenced by the wife he loves, he unwittingly is influenced to consider erroneous ideas.

5. She must be that rare person, an able individual who can remain anonymous—the power behind the throne, who never lets even the king suspect it. This means that she needs to reach the ultimate in unselfishness, to give without thought of reward or recognition—whose only reward is to be allowed to serve humanity in the humblest and most trying capacity, namely, as a doctor's wife.

6. She needs considerable physical vigor that she may tolerate early, late, and irregular hours. And since most medical men do not make much money, she is probably going to have to do most of the



housework as well as take care of the children without much help from her husband—all in addition to her other duties. So she needs to be husky—or, shall we say, physically tough. She must learn how to “take it,” because she is going to have to take plenty as long as she lives.

7. Domestic interests are an asset to any woman, particularly to a doctor's wife. The efficient, interested housekeeper makes a good home, setting an example of doing it with ease and grace. Most women know that they have to be housewives, but some resent it. A doctor's wife cannot do this. For one thing, the doctor does so many dirty jobs himself and has to do them efficiently, that he has little respect for an associate who will not do likewise. And once again, the watchful public expects the doctor's wife to set a good example by having an efficiently run house, well trained children, a sensibly organized personal life, and marital felicity. Since these are some of the things which the doctor is subtly teaching them, the public looks to see how well he succeeds in his own life. And, speaking of marital felicity, the public demands near perfection of the medical profession in this regard. Therefore, marital felicity is particularly important in the homes of doctors, and it is mostly up to the wife to make the home a happy, successful one, in face of the almost insurmountable problem that her husband is a doctor and therefore usually a neglectful husband. If there is marital infelicity it should be carefully concealed. After all, it is no one's business, it is a personal matter, and nothing injures a doctor much more than a doctor's wife discussing the trouble she has with her husband, and vice versa.

8. She should see to it that she looks her best and dresses attractively. She should not get fat or soft. Doctors are vain. All men like good looking women, and doctors are no exception to that rule. She will enjoy nice clothes, her husband will like it, and it is good policy so far as the public is concerned. I said nice clothes—not outstandingly expensive mink coats,, Hattie Carnegie dresses and loud jewelry. And I know I need not say that perfume is forbidden.

Being a doctor's wife carries a certain amount of occupational hazard, largely due to the realization that you are not first in your husband's interests (Medicine, you know, is his great love). You must learn to deal with loneliness and repressed anger. The latter, if it exists, may give rise to chronic depression, a sour disposition, or outbreaks of irri-

tability. If your husband makes you angry, remember not to consider your anger very important, but tell him you are angry, and explain that you do not consider your anger justifiable but you crave the opportunity of blowing off steam. Learn to laugh at your own anger. Express it as if it were a joke. It is not sufficiently significant to repress it.

All of which brings us to a consideration of the special technics of adjustment which a doctor's wife should know and practice, that she may be of greater assistance to the public, help her husband, and find greater happiness herself. Successful living is largely a matter of technics, the use of proven methods of adaptation, the whole built on a sincere desire to be of service, and to make one's life significant.

I shall mention in passing the general technics of living which all people should train themselves to observe. Perhaps these should be called “The Mental Hygiene Creed.” They are as follows:

1. I shall adapt to life, immediately, completely and gracefully.
2. I shall exercise, rest, work and play—every day.
3. I shall avoid undue fatigue.
4. I will discount harmful emotional urges, avoid emotional orgies, keep away from emotionally undisciplined people.
5. The five useless sentiments are: self-pity, suspicion, envy, jealousy, and revenge. The three dependable sentiments are: loyalty, courage, and kindness.
6. I shall work at a worthwhile job.
7. I face facts, discount my likes and dislikes, and cultivate an objective point of view.
8. I make clear-cut decisions and abide by them. I ask for counsel, consider it without argument, but let *no one* make up my mind for me.
9. I form good habits of living, acting, thinking, speaking and feeling.
10. I *choose* to see the good aspects and meanings of life. I do not deny that unfortunate facts exist and I do not overlook them, but having seen them *I choose to look for the good aspects*.
11. Knowing myself, I accept my liabilities and cultivate my assets.
12. I do not expect to get what I want in this world, and I cannot be sure that I shall in the next. I will not kick against the pricks of life. I expect trouble and have accepted inevitable difficulty, that I may be free to accept opportunity unhandicapped

by the sense of the difficult.

13. Fear, anxiety and worry cannot hurt me. They threaten to destroy, but they possess no weapons other than the ones I give them. Even though afraid, anxious and worried, I shall say "I'll get by," and continue with my normal activities, knowing that fear is the normal stimulus to courage. When the reality of courage walks with me fear is only a shadow.

14. I believe that I am one of God's Disciples; it is intended that my life have significance. God's hand is on my shoulder.

15. I am going to laugh *more* every day.

I shall not burden you with a reiteration of the small technics which a wife employs in dealing with patients and their families. You are by now experts in the practice of these. Encouragement, reassurance, a general attitude of helpfulness, and a willingness to listen even though the children are crying and the dinner is burning, become second nature to you by the end of the first year of marriage. I know that what you most want to know is how you may help the doctor himself, because I believe that in general he means more to you than anyone else in the world. This is not an easy question to answer, even in a general way, but I would suggest the following:

1. First, try to understand him. This is what all people want; only by understanding his peculiar nature and needs can you help him. It is not what *you think he should be*, but what *he actually is*, that you need to know. And you can understand him better if you know his medical friends and their wives. Therefore, accompany him to medical conventions, go with him on distant consultations, and, above all, encourage him to bring his medical friends home.

2. Help him to balance his life, in terms of work, rest, exercise and play. Do not keep him up late at night. Bring him home early from parties. Adopt the sports which you believe he will like and which would be good for him, and try not to be better at them than he is. Do things with him even to the neglect of everything else. Encourage him to take vacations, both with you and without you, but do not go off on long summer vacations while he remains at home working. He needs the comfort of a well run home at all times. Enrich his life by bringing to him constructive, cultural interests for which there is little time in his busy life—such as

music, the arts, reading, lectures, gardening, horticulture, flower arrangement, games, and interesting people. Doctors are likely to become onesided. Those who are not, usually owe it to their wives.

3. Help him to attain a reasonable amount of financial independence. Doctors are notoriously poor businessmen and their wives are little better. Be careful not to make too great financial demands on him. Help him to plan for the future. Budget your expenditures and help him to do likewise. Try to learn something about the art of handling money yourself. Most doctors need a good business manager and it is to their credit that they do. It would be both a material and a spiritual economy if he employed someone to act in this capacity. Encourage him to have a business counsellor with whom he is perfectly frank and whose advice both of you take.

4. Give him of yourself, wholeheartedly, without stint, spiritually and physically. Be warm, generous, uncritical and encouraging. In the doctor's life there are occupational hazards. You are first and foremost *his* doctor and he is frequently a somewhat sick man spiritually. Only you can cure him.

5. Encourage him to write medical papers, read medical journals, and go to medical meetings. He should give up medicine unless he does these things. Stay up and wait for him when he comes home late from meetings. Provide a comfortable place for him to rest and study. And leave his books and papers alone.

In concluding these remarks, I wish to express to you, in the name of the entire medical profession, the affection, admiration and gratitude which all of us feel for you, the handmaidens of medicine. We humbly acknowledge a debt which we can never repay, even were we the supermen we are not. We grant our many failings, as husbands, and realizing that we will seldom correct these failings, throw ourselves on your mercy and love.

Shakespeare must have had the psychology of the doctor's wife in mind when he wrote his fifty-seventh sonnet:

Being your slave, what should I do but tend  
Upon the hours and times of your desire?  
I have no precious time at all to spend,  
Nor services to do, till you require.  
Nor dare I chide the world-without-end hour  
Whilst I, my sovereign, watch the clock for you,  
Nor think the bitterness of absence sour



When you have bid your servant once adieu;  
Nor dare I question with my jealous thought  
Where you may be, or your affairs suppose,  
But, like a sad slave, stay and think of nought  
Save, where you are how happy you make those!  
So true a fool is love, that in your will,  
Though you do anything, he thinks no ill.

**Board of Directors Meeting, May 23, 1947**

The meeting of the Board of Directors was called to order by the president, Mrs. Robert J. Cook at 11 A. M. Other members present were Mrs. Gold, Mrs. Connors, Mrs. Howard, Mrs. Pennington, Mrs. Wight, Mrs. Arnold, Mrs. Tisher, Mrs. DiStasio, Mrs. Stringfield, Mrs. Russell, Mrs. Goff, Mrs. Wellington, Mrs. Hewes, and Mrs. Tracy. The minutes of the annual meeting were read by the recording secretary, accepted and placed on file. A motion to approve the minutes of the last Board of Directors meeting, as received by each member, was made, seconded and carried.

The treasurer's report was read and accepted.

Reports of County presidents and Standing Committee chairmen were read and accepted.

**FAIRFIELD**

Mrs. Stringfield reported a Board meeting held May 5 at which time plans were made to raise and collect money for Laurel Heights Sanatorium to be used by Mrs. Kinsey for occupational therapy and rehabilitation. Mrs. Howard spoke further on the Laurel Heights Project saying that the appropriation by the State for this work had been cut this year.

**HARTFORD**

Mrs. Tisher reported that they had staffed a table in the railroad station for one week during the Cancer Drive. May 1 a tea was given for the new officers. June 3 there will be a bridge luncheon with New Britain members as hostesses. The Welfare Project of last year with Mrs. Carniglia as chairman will be continued this year—it being to show movies one hour each week to shut in children. There will be a June Board meeting to discuss plans for the year.

**LITCHFIELD**

Mrs. Wight reported that at their spring meeting members brought magazines to be distributed to the mental hospitals. The fall meeting will be held in Norfolk in September.

**NEW HAVEN**

Mrs. Pennington reported that the May Board meeting was held on the 15th at which time only program was discussed. There will be a June meeting.

**NEW LONDON**

Mrs. Hewes reported a Board meeting held May 9 which was mainly devoted to committee appointments.

**WINDHAM**

Mrs. Arnold reported that Dr. Guthrie from Norwich spoke at their last meeting. The Willimantic group acted as hostesses. They plan to collect magazines for the Mental Hospitals.

**REPORTS OF STANDING COMMITTEES**

*Publicity Chairman*—Mrs. Howard read excerpts of publicity she had received for the National Convention. Copies of this release had been sent to County chairmen to be used in every State newspaper June 8.

*2nd Vice-President*

*Program Chairman*—Mrs. Gold reported she had secured Dr. Morris Fishbein as the speaker for the fall meeting. His subject has not been decided upon, but she was given authority at this meeting to set the date in the first or second week of November. The meeting will be held in Hartford.

*1st Vice-President*

*Organization Chairman*—Mrs. Goff reported seven of eight counties in State organized; and she proposed to write to interested doctors' wives in Tolland County (the one unorganized county) and see if they would like to become members of State Auxiliary. There are five hundred and sixty-three members in the state now.

*Public Relations*—Mrs. Tracy discussed the work last year. It was felt that it might prove effective to have a chairman with assistant chairmen in charge of public speaking and publicity.

Mrs. Cook read and discussed amendments to be made to the National Constitution at the Convention. It was decided that delegates may vote in favor of the amendments.

Mrs. Wellington invited the Board to hold their next meeting at her summer home, Long Island Sound, New London, August 6 at 11 A. M.

The meeting adjourned at 3 P. M.

## Woman's Auxiliary to The Fairfield County Medical Association

A luncheon and business meeting of the Executive Board of the Woman's Auxiliary to the Fairfield County Medical Association was held at the home of Mrs. Oliver Stringfield, Stamford, May 5, 1947. The new officers and committee chairmen for this year are: President, Mrs. Oliver Stringfield, Stamford; President-Elect, Mrs. J. Grady Booe, Shelton; Vice-President, Mrs. Chester Haberlin, Stratford; Recording Secretary, Mrs. Paul Brown, Stamford; Corresponding Secretary, Mrs. David McGourty, Stamford; Treasurer, Mrs. Frank Turchik, Bridgeport; Publicity, Mrs. Allan M. Ross, Darien; Legislative, Mrs. Newell Giles, Glenbrook; Public Relations, Mrs. Troutman, Bridgeport; Program, Mrs. Harold Weber, Greenwich; Finance and Budget, Mrs. William Geer, Stratford; Constitution and By-laws, Mrs. John Booth, Danbury; Nominating, Mrs. Harold Amoss, Greenwich; Project, Mrs. Joseph Howard, Bridgeport.

Plans were made for a box lunch at the Pequot Yacht Club, Southport, June 24, for the purpose of raising money for the Department of Occupational Therapy and Rehabilitation at Laurel Heights Sanatorium. Mrs. Lambert will be the hostess.

## Woman's Auxiliary to The Hartford County Medical Association

At a meeting of the officers of the Woman's Auxiliary to the Hartford County Medical Association, held April 7 in Hartford, the following business was transacted:

Mrs. E. M. Andrews, West Hartford, was authorized to staff a table at the station in Hartford for the Cancer Drive during the week of April 21. She was assisted by Mrs. Freeman P. Clason, Mrs. Ralph Tovell, Mrs. Paul S. Phelps, Mrs. L. Roger Morse, Mrs. Albert Rubin, Mrs. H. D. Apter, Mrs. Grant J. Irving, Mrs. J. Whitfield Larrabee, Mrs. Maurice Pike, Mrs. Harvey Goddard, Mrs. Michael Zeman, Mrs. Irving Krall, Mrs. R. M. Filson, Mrs. Charles K. Wallace, and Mrs. John H. T. Sweet.

Standing committee chairmen for the year 1947-1948 were appointed as follows: Membership, Mrs. Frank S. Jones, West Hartford; Legislative, Mrs. Bliss B. Clark, New Britain; Publicity, Mrs. Reginald C. Edson, West Hartford; Hospitality, Mrs. Edmund Beizer, Hartford; Public Relation, Mrs. Arthur C.

Unsworth, West Hartford; Budget Director, Mrs. James E. Stretch, Simsbury; Art and Decoration, Mrs. John D. O'Connell, West Hartford; Courtesy and Necrology, Mrs. Amos E. Friend, Manchester; Welfare, Mrs. Ettore Carniglia, Windsor Locks; Telephone, Mrs. Wendell Hall, West Hartford; Historian and Custodian, Mrs. L. Roger Morse, Newington; *Hygeia*, Mrs. John Gallivan, East Hartford; Musical Director, Mrs. Robert S. Buel, New Britain; Revisions, Mrs. Stanley Osborn, West Hartford; Delegate-at-large, Mrs. Paul S. Phelps, Canton Center. These chairmen with their committee members have been invited to be guests of the officers at a meeting and tea at the home of Mrs. J. Whitfield Larrabee.

A luncheon and bridge will be held for the members of the Woman's Auxiliary to the Hartford County Medical Association at Shuttle Meadow Club, New Britain, June 3, at 12:30 P. M. Local hostesses are Mrs. Charles N. Sullivan, Mrs. George W. Dunn, Mrs. Donald A. Bristoll, Mrs. Bliss B. Clark, Mrs. Louis W. Daley, Mrs. Robert S. Buol, Mrs. John C. White. Mrs. Paul Tisher will assist Mrs. Edmund Beizer, hospitality chairman, and her committee, Mrs. Louis Antupit, Mrs. John C. J. McLean, Mrs. Loftus L. Walton and Mrs. J. G. M. Olmsted.

## Woman's Auxiliary to The New Haven County Medical Association

Mrs. Raymond V. Quinlan was elected president of the Meriden Chapter of the Woman's Auxiliary of the New Haven County Medical Association at the annual meeting and luncheon held Tuesday afternoon, May 20, at the Oakdale Tavern in Wallingford. Other officers elected for the coming year are as follows: Vice-President, Mrs. Edward R. Smith, Meriden; Recording Secretary, Mrs. Thomas B. Murphy, Wallingford; Corresponding Secretary, Mrs. Joseph F. Misuk, Meriden; Treasurer, Mrs. Lawrence E. Thompson, Meriden.

The retiring president, Mrs. George G. Fox, read a report on the activities of the state, county and local auxiliaries during the past year. Mrs. Fox stated the purposes of the auxiliary:

"To create a better understanding between the public and the medical profession by urging busy husbands to keep abreast of the times by attending medical meetings.

"To avail ourselves of the opportunities to learn



of current medical legislation by attending state and county auxiliary meetings.

"To extend our health information and aims to the public."

Mrs. H. Freeman Pennington, president of the county auxiliary, gave a detailed report on the progress of the auxiliary since its organization four years ago at Bridgeport.

The guest speaker, Miss Grace C. Nicholson, director of the Meriden Hospital School of Nursing, spoke on "The Effects of New Trends in Medicine on Nursing Service." Miss Nicholson emphasized the fact that due to increased chemotherapy in modern medicine, nurses find it necessary to devote more time to the preparation and administration of medications than to bedside care, thereby necessitating the enlargement of the nursing staffs.

Members of the auxiliary who were present in addition to those mentioned were Mrs. Stanley J. Boguniecki, Mrs. Roger Boyd of Wallingford; Mrs. Sherburne Campbell of Wallingford, Mrs. James Giddings, Mrs. Francis Giuffrida, Mrs. Frederick P. Glike, Mrs. William E. Hall, Mrs. Frank J. Konopka of Wallingford, Mrs. Stephen L. Lirot, Mrs. Walter Lohrmann, Mrs. Joseph A. Mekrut, Mrs. Bernard L. Mills, Mrs. Israel S. Otis, Mrs. Kurt Pelz of Wallingford, Mrs. Louis A. Pierson, Mrs. Samuel A. Robb, Mrs. Allen J. Ryan, Mrs. James S. Van Leuvan, and Mrs. J. Alfred Wilson.

The first monthly board meeting of the Woman's Auxiliary of the New Haven County Medical Association was held Thursday afternoon, May 15, at the home of Mrs. H. Freeman Pennington, 119 Williams Street, Meriden.

Reports from members of the Board on the progress of the Auxiliary were read and approved. The type of program for the coming year was discussed and the members of the board decided to pursue a definite medical subject designed to educate and to equip all members of the Auxiliary for better service to the public in matters pertaining to the health and welfare of the communities in which they reside.

Each chairman was requested by Mrs. Pennington to form a committee of three or more assistants and to present their names at the board meeting in June.

Officers and committee chairmen for the year 1947-48 are as follows: President, Mrs. H. Freeman Pennington, Meriden; President-elect, Mrs. Arthur

H. Morse, Hamden; Vice-President, Mrs. Lewis C. Foster, Hamden; Recording Secretary, Mrs. Paul W. Vestal, Woodbridge; Corresponding Secretary, Mrs. George G. Fox, Meriden; Treasurer, Mrs. Joseph L. Hetzel, Waterbury; Program, Mrs. Lewis C. Foster, Hamden; Legislation, Mrs. John H. Foster, Middlebury; *Hygeia*, Mrs. Barnett P. Freedman, New Haven; Finance, Mrs. Ralph W. Nichols, New Haven; Publicity, Mrs. Edward R. Smith, Meriden; Public Relations, Mrs. John H. Bumstead, Hamden; Hospitality, Mrs. John M. Renchan, Ansonia; Volunteers, Mrs. Frederick W. Roberts, Hamden; Nominating, Mrs. Edward T. Wakeman, New Haven.

### South Carolina's Woman's Auxiliary Bulletin

The South Carolina Medical Association has created a Bulletin especially prepared for the members of the Woman's Auxiliary. The Bulletin is the result of the suggestion of Dr. James McLeod, the Association's president, and is to act as a medium through which to cultivate the relations of the profession with the general public of South Carolina. Dr. McLeod felt it necessary to enlist the aid and cooperation of the Woman's Auxiliary which in turn would increase vastly the contact between the profession and the general public.



## SPECIAL NOTICES

### INDIANA REQUIRES ANNUAL REGISTRATION

Board of Medical Registration and Examination of Indiana  
K of P Building—Indianapolis 4, Indiana

#### Important Notice

Chapter 254 of the 1947 Acts of the General Assembly of Indiana, requires; That, every person who now holds, or may hereafter hold, a valid and unrevoked certificate for a license to practice the Healing Art in any form or manner, granted by the Board of Medical Registration and Examination of Indiana, shall be required to register with said Board, during the month of July and not later than the last day of August, immediately following the effective date of this Act, which registration shall be for the period ending June 30, 1948, and shall, annually thereafter, on or before August 31 of each year, be required to register with said Board. Each applicant for registration shall remit with his application the sum of five (\$5) dollars as the annual registration fee if he resides within the boundaries of the State of Indiana; and if residing outside the boundaries of the State of Indiana, shall remit the sum of ten (\$10) dollars as the annual registration fee; Provided, that no registration or fee for registration shall be required of any holder of a certificate on or before the month of July of the year following the year within which such certificate was issued. Failure to comply with provisions of this Act shall operate automatically to cancel his/her certificate, and any license issued thereunder, and continued practice after cancellation of the certificate and license issued thereunder shall be considered as practicing without license. A certificate cancelled for failure to register may be reinstated by said Board upon submission of the applicant's last registration certificate together with current and delinquent fees, and a penalty in the sum of ten (\$10) dollars.

Fee must accompany application to this Board not later than August 31.

### WORLD PEDIATRICS CONGRESS IN U. S.

Twenty-two hundred leading specialists in children's diseases from fifty countries will assemble for the fifth International Congress of Pediatrics at the Waldorf-Astoria Hotel in New York, July 14 to 17. It will be the first meeting of the congress to take place in America. The previous congresses were held in Paris, Stockholm, London and Rome.

Fourteen delegates will attend from the United States and Canada, 450 from Latin America, 250 from Europe and 100 from other parts of the world. In the belief that world good health will promote cooperation, the congress will stress the "one world" theme.

President of the congress is Dr. Henry F. Helmholtz of the Mayo Clinic, Rochester, Minn.; Dr. L. Emmett Holt, Jr., professor of pediatrics at New York University and chief of the Bellevue Hospital pediatric staff, is general secretary; Dr. Donovan J. McClune of Babies Hospital at

Columbia-Prebyterian Medical Center is assistant secretary and treasurer.

Sponsoring the congress will be the pediatric section of the American Medical Association, the American Academy of Pediatrics, the American Pediatric Society and the Society for Pediatric Research.

The program will include reports on scientific advances in pediatrics in the United States and other countries during the war; reports on studies made of malnutrition among the Dutch, Norwegian, Danish and German children; and discussions by leaders in the field of nutrition, virus diseases, chemotherapy and neonatal mortality. All possible information will be made available to all to insure the health of future generations.

### THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-fifth annual scientific and clinical session September 2, 3, 4, 5 and 6 inclusive, at the Hotel Radisson, Minneapolis. Scientific and clinical sessions will be given the days of September 3, 4, 5 and 6. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 2, 3, 4 and 5. These courses will be open to physicians and the therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

### TWELFTH ANNUAL ASSEMBLY INTERNATIONAL COLLEGE OF SURGEONS

The United States Chapter of the International College of Surgeons will hold its 12th Assembly and Convocation at the Palmer House, Chicago, October 1, 2, 3 and 4. The announcement promises an impressive scientific program, as well as operative clinics and round table discussions. Applications for hotel accommodations should be made at once to Dr. Francis D Wolfe, Chairman, Housing Committee, 33 North LaSalle Street, Chicago 2, Illinois.

### American Heart Association Supports National Heart Disease Bill

The Board of Directors of the American Heart Association has unanimously approved a bill proposing the creation of a National Heart Disease Institute. The bill has been introduced in Congress by Representative Jacob K. Javits of New York.



## OUR NEIGHBORS

### Massachusetts

James M. Faulkner, M.D., professor of medicine, Tufts College Medical School, is now dean of Boston University School of Medicine, succeeding Donald G. Anderson, M.D. Dr. Anderson resigned to accept a position as secretary of the Council on Medical Education and Hospitals of the American Medical Association. Dr. Faulkner is a native of New Hampshire and a graduate of both Harvard College and Harvard Medical School.

Edward P. Bagg, M.D., of Holyoke is the new president of the Massachusetts Medical Society.

#### EYE BANK IN BOSTON

An affiliated "Eye Bank" has been organized in Boston and is ready to serve the needs of New England. The Boston Eye Bank is located in the Massachusetts Eye & Ear Infirmary building at 243 Charles Street. Seven hospitals in the Boston area and one in Maine have already become affiliated with it. The general public in New England is being urged to sign forms, available from the Boston Eye Bank, indicating their willingness to donate their eyes for use after death.

Henry Hixon Meyer, William S. Ballard and Dr. Edwin B. Dunphy constitute the executive committee of the Boston Eye Bank's Board of Sponsors. The Board includes leading ophthalmologists throughout New England; business, industrial and religious leaders; and representatives of the eye departments of various hospitals in the area.

The demand for eyes still exceed the supply, Mrs. Breckinridge, the executive director at national headquarters said, and there is a long waiting list of people who might benefit by a corneal transplant operation. Particularly deserving of credit for their cooperation, she added, are the Red Cross Motor Corps and important airlines which transport eyes to the Eye Bank and to hospitals.

### New Jersey

The American Cancer Society, New Jersey Division, Inc., with the cooperation of the medical and related professions, has just made available in pamphlet form the findings in a statistical research

program conducted by the Society's State Service Department. The report gives a detailed and illuminating picture of the cancer mortality situation in the state as a whole and in each of the twenty-one counties. The report shows a definite and steady increase in the cancer mortality rate for New Jersey in the last twenty-five years, the figure for 1945 being almost double that for 1920. The digestive organs and the peritoneum lead all organs affected in both male and female. The age group most affected has shifted from the decade 60 to 69 years to the 70 years and over group.

### New York

Leo F. Simpson, M.D., of Rochester, N. Y., is the new president-elect of the Medical Society of the State of New York.

#### NEW YORK UNIVERSITY INAUGURATES INSTITUTE OF INDUSTRIAL MEDICINE

Officials of New York University recently inaugurated the institute of Industrial and Social Medicine as a unit of its New York University-Bellevue Medical Center, and announced that Dr. Anthony J. Lanza, one of the nation's leading authorities in the field of industrial health, will join the Institute as professor of industrial medicine.

In announcing the new Institute and the appointment of Dr. Lanza, Dean Currier McEwen, of the New York University College of Medicine, said the Institute will offer training for both professional and lay workers, and will award appropriate degrees. There will be in operation in conjunction with the Institute a new general group practice clinic, staffed by members of the College faculty. The general clinic will be in operation by next Fall, he said, and will offer to wage earners a comprehensive program of medical care.

He added that there will also be offered a graduate program, not only to qualified physicians, but to others wishing to specialize in the field. The Institute will also offer industry special services covering research in toxicology, physiology, worker psychology, and tropical medicine.

A veteran of both world wars, where he pioneered in industrial health work, Dr. Lanza holds the Legion of Merit, and in 1946 received the William S. Knudsen award for the most significant contribution to the field of medicine. He is associate medical director of the Metropolitan Life Insurance Company.

Dean McEwen announced that Dr. Lanza will give voluntarily half-time service until the end of 1948, after which he will be able to devote his full time to the new program of the College of Medicine. He will act as co-director of the Institute with Dr. Henry E. Meleney, professor of preventive medicine.

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## News from Yale University School of Medicine

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### Yale School of Medicine Announces New Appointments

The appointment of Prof. C. N. H. Long as dean of the School of Medicine was announced by President Seymour at the Alumni luncheon on Monday, June 16. Dr. Long came to Yale in 1936 as the successor of Prof. Lafayette B. Mendel, Sterling professor physiological chemistry. The pioneer studies on metabolism of Prof. Mendel associated with Prof. Thomas B. Osborne, it was recalled, had placed Yale in the foreground as the center of education and investigation of metabolism. This leadership has continued under the able direction of Dr. Long in the period when the importance of the subject has expanded greatly with the demonstration of the intimate control many of the ductless glands exercise over metabolism.

Dr. Long had achieved wide recognition for his contributions to science, both at McGill University, 1925-32, and as the director of the George M. Cox Research Institution at the University of Pennsylvania, 1932-36, before he joined the Yale Faculty.

With the constantly expanding staff of able representatives in the various subdivisions of the subject, his department has not only retained, it has advanced its position of leadership in both endocrinology and metabolism.

Dr. Long has been closely associated with the administration of the School of Medicine since he joined the Yale Faculty. As acting dean in 1943, and more recently as chairman of the Executive Committee of the School, he has demonstrated fully his broad comprehension of the many aspects of administration in medicine. His appointment assures continuance of the intellectual growth of the School of Medicine as a section of the University.

Dr. Long succeeds Dr. Francis G. Blake, who has

served with distinction as dean during the past seven years, including the war period. He continues to serve as professor and chairman of the Department of Internal Medicine and as physician-in-chief of the Grace-New Haven Community Hospital, positions he has occupied since 1921.

Dr. Blake's contributions to the nation as consultant to the Secretary of War and as president of the Board for the Investigation of Epidemiological Diseases were recognized by the Award of the Medal of Merit.

Other appointments at the School of Medicine include: Dr. Donald H. Barron as professor of physiology, Dr. Daniel C. Darrow as professor of pediatrics, and Dr. Herbert Thoms as professor of obstetrics and gynecology and chairman of the department.

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## NEWS

### *from County Associations*

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#### Fairfield

E. Everett Rowell, Stamford roentgenologist, has resigned from the Common Council of that city because of continued ill health.

The regular monthly meeting of the Bridgeport Medical Association was held at the University Club on Tuesday evening, June 3, at 8:30. The program diverted from the usual scientific talk in that it consisted of a round table discussion on the subject, "Sudden Death," with reference to the responsibilities of the physician. Mr. James Kranyik of Fairfield, Chief of Police, spoke on the police angle and Dr. Benjamin Horn and Dr. H. R. Deluca spoke on the duties of the medical examiner. The legal discussion was given by Attorney George Saden, and County Coroner Theodore E. Steiber of Bridgeport concluded a very informative and interesting evening. The discussion was lively and showed the interest the subject aroused in the majority present. A buffet luncheon was served.

Crawford Griswold is spending the month of June at his estate in Lyme, New Hampshire. Maurice Cheney is sojourning at his country home in Vermont for the summer. The following new members have been added to the roster of the Bridgeport Medical Association: John Donadeo, Vincent



Lynch, Mildred Pellens, Joseph Chiota, James L. Hanley, James M. O'Brien, and Mr. James M. Dunlop, superintendent of Bridgeport Hospital, was admitted as an associate member.

M. David Deren, M.D., former chief of the division of gerontology, New York Postgraduate Hospital, has been appointed to serve as specialist in internal medicine and cardiology at the subregional office of the Veterans Administration in Bridgeport.

The Fairfield County Medical Golf Association reorganized after a five year interval because of the war. The first tournament was held at the Mill River Country Club on May 28 with sixteen members present. Fourteen of these members stayed to dinner and the organization meeting. Officers elected were: President, Edwin F. Trautman; Vice-President, Roger terKuile; Secretary-Treasurer, George A. Buckhout. Local chairmen: Richard Sekerak, Bridgeport; John D. Booth, Danbury; Robert Hansell, Greenwich; John G. Frothingham, Darien.

The winners of this tournament were: Low gross, John G. Frothingham, 87; Edwin F. Trautman, 89; Moses Deren, 92. Low net, Edwin Connors, 95-25; J. Grady Booe, 95-24; Leonard Scalzi, 100-25; Edwin Trautman, 89-14. Kickers Handicap, Robert Hansell; Joseph Esposito; George Warner.

H. P. Serrell was elected president of the Greenwich Medical Society for the coming year at a meeting held last evening at Greenwich Hospital. Dr. Serrell succeeds Dr. J. V. Shermak, retiring president. Other officers elected include Gray Carter, vice-president, and W. B. Swarts, secretary and treasurer. Plans were made for the June outing of the society. Dr. Julian Hawthorne was named chairman of the arrangements committee.

Henry Clifford Sherer, M.D., prominent local physician for more than half a century, died on May 26 in the Norwalk Hospital after a long illness.

**Hartford**

Charles Coffing Beach, M.D., for more than half a century a practicing physician in Hartford, has resigned as consulting medical director of the Travelers Insurance Company. Dr. Beach was instrumental in setting up the present system of reviewing medical reports and analyzing life insurance applications.

Henry Stempa, M.D., Wethersfield, former resident physician at Cedarcrest Sanatorium for more than ten years died recently at Hartford Hospital

after a brief illness. He had conducted his own practice at his home for the last seven years. He resigned from state service in 1940.

**Litchfield**

The 185th annual meeting of the Litchfield County Medical Association was held at the Litchfield County Hospital in Winsted, on April 22.

Cole B. Gibson, president of the Connecticut State Medical Society, reported that the house of medicine in Connecticut is in good order. He called attention to the Committee to Study Organization and Objectives of the Connecticut State Medical Society. James R. Miller, president-elect of the State Society, spoke briefly on the prepaid medical care plan. His opinion is that the cash indemnity type is the best one for Connecticut. He also reported on the activities of the A.M.A. Thomas P. Murdock, chairman of the council, reported on the activities of the Council. James D. Gold, delegate from Fairfield County, and M. H. Merriman, delegate from New Haven County, brought greetings from their counties. Mr. James G. Burch, public relations director, stated that a complete report on Public Relations would be published in the CONNECTICUT STATE MEDICAL JOURNAL.

The following were elected to membership: Joseph Carey Reidy, Winsted; Graham Burt Blaine, Jr., South Kent; David Arthur Grendon, Kent, transferring his membership from the Medical Society of the County of New York.

The following resolution on Requirements for Staff Membership was presented:

WHEREAS, The problem of hospitalization is urgent now and will be distressingly difficult for an indefinite period of time; and

WHEREAS, There is apparently a definite plan to limit staff membership in hospitals to diplomates of the various specialty boards; and

WHEREAS, The various specialty boards are self appointed, self perpetuating groups with no connection with the American Medical Association; and

WHEREAS, The limiting of staff memberships and heads of departments of such staffs in hospitals to such diplomates could tend to injure the best interests of the public and the medical profession as a whole; and

WHEREAS, Of a total of 180,000 physicians in the United States approximately only 22,000 are diplomates of all specialty boards, and limitation by the hospitals of their facilities to use by these few would

work an injustice on other capable doctors and their patients; therefore

BE IT RESOLVED, That the House of Delegates of the Connecticut Medical Society go on record as favoring the following suggestions in regard to staff membership in hospitals;

1. Adequate protection of the rights of all doctors and their patients in obtaining hospitalization to the end that general practitioners as well as specialists shall have access to and use of hospital facilities;

2. That the criterion of whether a doctor may be a member of a staff or head of a department shall be his actual ability as a doctor and not dependent on special society or board membership.

A motion was carried that this be presented to the meeting of the House of Delegates of the Connecticut State Medical Society by the delegates of the Litchfield County Medical Association.

The following resolution regarding physicians who are debarred from hospitals was presented:

WHEREAS, It has recently come to the attention of the members of this society that six reputable physicians, all members of the Connecticut State Medical Society, have been advised by three general hospitals of this state that they may no longer practice in these hospitals for reasons that have nothing to do with the proper practice of medicine; and

WHEREAS, They have not infringed on the codes of these hospitals while pursuing their professions within their walls; and

WHEREAS, These hospitals accept public funds raised by general taxes from all the people of this state regardless of their religious beliefs; and

WHEREAS, The action of these hospitals in denying their facilities to these doctors sets a dangerous precedent which may well result in the debarring all physicians who do not conform in their entirety to the religious beliefs of those governing these hospitals; therefore

BE IT RESOLVED, That the Litchfield County Medical Association at its annual meeting held April 22, 1947, voices its disapproval of the action taken by these hospitals and that a copy of this resolution be sent to all general hospitals in the State of Connecticut.

It is moved that the Delegates of this Association to the State Medical Society be instructed to call this resolution to the attention of the House of Delegates at its meeting in New Haven on April 28 and request the House of Delegates to take such action as it may see fit to the end that properly qualified

physicians may not be debarred from practicing their profession in public hospitals because of their religious beliefs.

This motion was passed.

The following officers were elected: President, Winfield E. Wight, Thomaston; Vice-President, Frank L. Polito, Torrington; Secretary-Treasurer, Thomas J. Danaher, Torrington; Councilor, Floyd A. Weed, Torrington; Censors: John F. Kilgus, Jr., chairman, Michael E. Giobbe, and Roy V. Sander-son; Committee on Ethics and Deportment: Floyd A. Weed, chairman; Richard I. Barstow, Norfolk; Donald W. Herman, Winsted; Charles H. Turking-ton, Litchfield; Edwin G. Reade, Watertown; Com-mittee on Public Policy and Legislation: W. Brad-ford Walker, chairman; Gaert S. Gudernatch, Sharon; John R. Elliott, Canaan; State Delegates: Thomas J. Danaher, Torrington; W. Bradford Walker, Cornwall; Richard I. Barstow, Norfolk.

Retiring President Walker delivered a short inter-esting address on coronary disease. R. Starr Lampson of Hartford presented a very interesting discussion on "Problems in Thoracic Surgery as Seen in a Gen-eral Hospital." He emphasized the diagnosis and treatment of pneumothorax, empyema, lung ab-scesses and neoplasms of the lung.

Josephine Evarts, M.D., of Kent was married in the chapel of St. Bartholomew's Church on May 10 to Gilbert Stevens Tabor, M.D., of Millerton, N. Y. Dr. and Mrs. Tabor are both attending physicians at the Sharon Hospital. They will make their home in Millerton.

## New Haven

The 163rd annual meeting of the New Haven County Medical Association was held at the New Haven Country Club on Thursday, April 24. The business meeting was highlighted by the election of 32 new members, bringing the active total member-ship to 701. Officers elected for the year 1947-1948 are: Ralph E. McDonnell, president; Samuel B. Rentsch, vice-president; Courtney C. Bishop, clerk. Upon installation of the new officers, the retiring president, M. Heminway Merriman, presented the annual address entitled "A History of Otolaryn-gology in Connecticut."

Following a pleasant social hour, dinner was served to 105 members. Following dinner, James R. Miller, Thomas P. Murdock, Stanley B. Weld and Creighton Barker reported briefly on the activities of the State Society. The paper of the evening was



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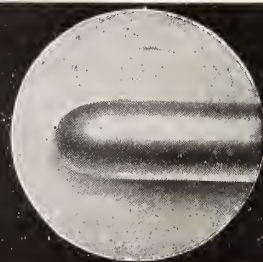


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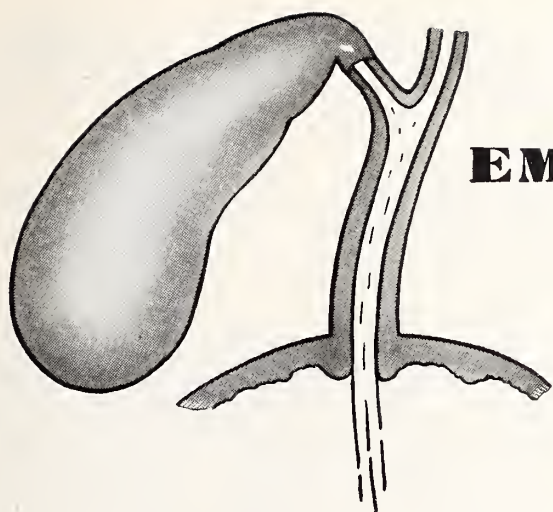
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presented by Mr. Thomas H. Dodd, special assistant prosecutor at the War Criminal Trials recently held in Nuremberg. Mr. Dodd presented most graphically the philosophy upon which the trial was based and described in part the overwhelming mass of evidence that was introduced to establish beyond doubt the guilt of the 21 defendants.

Edward R. Smith, M.D., of Meriden has been appointed as assistant resident in surgery at the New Haven Hospital.

**Windham**

There has been considerable activity in the census department of the medical profession in Willimantic. Two of the recent additions to the local practicing profession have left the city, and two of the old-timers who for reasons of ill health have found it necessary to stop practice for an extended number of months have now returned to active practice.

Louis G. Welt closed his office May 15, and is going to Washmington, D. C., where he will work

with the Division of Research and Education of the Veterans Bureau in Washington, D. C. Deborah Leary Welt has likewise closed her office and will go to Washington also. Her plans are still indefinite. Both Drs. Welt, although recent additions to the local practitioners, have had from the start quite active practices and their absence will be certainly felt in this community. Louis G. Welt was the first physician to limit himself to a practice of internal medicine here and his training and acumen were appreciated by both the profession and his patients.

Arthur Marsh, who found it necessary to stop his practice in Hampton quite a few months ago, has been markedly benefited by his rest and is now back at his office exhibiting his old cheerfulness and capacity to work. Likewise E. J. Ottenheimer, who has found it necessary to enjoy an enforced vacation, is now returning to his practice.

In Putnam, Robert Dinolt is establishing his EENT practice, confining himself entirely to his specialty. The Putnam practitioners say that he fills a long needed position in that district.

## NEW BOOKS IN REVIEW

*CLINICAL ALLERGY—A Monograph on the Management and Treatment of Allergic Diseases.* For General Practitioners and Students of Allergy. By *Alexander Sterling, M.D.*, Diplomate in Internal Medicine, Fellow of the American Academy of Allergy. Assisted by *Bea Sterling Hollander, A.B., M.D.* New York: International Universities Press. 1947. 198 pages. \$5.00.

Reviewed by *GEORGE HURWITZ*

This is an unorthodox little book in which the author's sincerity and earnestness in his efforts to be clinical, practical, and informative are apparent. But they are somewhat frustrated by a confusing notebook style, hasty writing and poor proof reading. Some of his teachings too are dubious, such as using dust extract and vaccine for the common cold, daily injections of pollen extracts to prevent constitutional reactions, immunization with epidermal extracts even in the absence of clinical contacts, and the classification of English plantain as a mid-summer pollen.

Nevertheless, the author's highly individual opinions evolved out of wide experience do merit close attention. He emphasizes the patient's nutrition, avoidance of fatigue, and the psychological factors, and he makes many practical suggestions for non specific and symptomatic treatment. Numerous case reports which exemplify his practices are a valuable didactic aid. The best feature of the book is the very simplified discussion of the laboratory setup which should enable anyone to make extracts satisfactorily, inexpensively and in little time.

In spite of its many drawbacks the book is recommended.

*THE PHARMACOPOEIA OF THE UNITED STATES OF AMERICA.* Thirteenth Revision (U.S.P. XIII). Prepared by the Committee on Revisions and Published by the Board of Trustees. Easton, Pa.: Mack Publishing Co. 1947. 957 pp. Price \$8.00 to include copy of Bound Supplement.

Reviewed by *STANLEY B. WELD*

Since the publication of the Twelfth Revision of the Pharmacopoeia eleven sheet supplements and a bound supplement have been issued, carrying 34 new drugs and preparations and 175 other revisions. In the present revision (U.S.P. XIII) an effort has been made to restrict admissions to those therapeutically active agents, germicides, anesthetics, diagnostic agents, and other necessary medical aids, which reflect the best state of medical knowledge of today, and to the preparations of these whereby they may be most efficiently administered or used. Substances required for the manufacture of preparations are also included and standardized.

For the first time in the U. S. Pharmacopoeia, now 127 years old, the English titles of drugs and preparations occupy the leading position with Latin titles following. This arrangement simplifies the format and makes unnecessary a separate list of dosage forms. The articles added to this revision are listed separately in the front of the volume; likewise, previous official articles omitted in this revision are listed. Changes in official English titles and in official Latin titles are given, also a list of English and Spanish titles. At the end of the volume may be found the usual section on General Tests, Processes and Apparatus and another on Reagents, Test Solutions, etc. A coupon entitling the holder to a copy of the First Bound Supplement to U.S.P. XIII is included with the volume

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**OBSTETRICAL PRACTICE.** (Fourth Edition.) By *Alfred C. Beck, M.D.*, Professor of Obstetrics and Gynecology, Long Island College of Medicine; Obstetrician and Gynecologist-in-chief, Long Island College Hospital, Brooklyn. *Baltimore: Williams & Wilkins Co.* 1947. 966 pp. Over 1,000 illustrations. \$7.00.

Reviewed by **STANLEY B. WELD**

There is very little new offered in this latest edition of Beck's *Obstetrical Practice*. What there is may be included under three headings: (1) a rewriting of the material previously presented on the new early human ova; (2) the use of penicillin in pregnancy complicated by syphilis and in puerperal infection; and (3) a new chapter on Analgesia, Amnesia and Anesthesia. The author acknowledges his indebtedness to the Contributions to Embryology of the Carnegie Institute for the written material and for the source of the illustrations accompanying this part of the text. The chapter on Analgesia, Amnesia and Anesthesia is an excellent one covering the important substances used in a brief but comprehensive manner.

It is a bit difficult to understand why the author has not attempted to present other changes in thought which have appeared since the previous edition five years ago. For example, the discussion of the Rh factor is very inadequate. The outline of postpartum care may follow the routine of a few hospitals and homes, where deliveries occur in the latter, but it is doubtful if many active obstetrical departments keep patients in bed seven to ten days after labor or proceed with such a conservatively graded course of exercises as the author outlines. His evaluation of the place of the nurse in the attainment of successful breast feeding is all too true, but where do we find more than an occasional such "cheerful, competent and considerate nurse"?

Beck's *Obstetrical Practice* will continue to be a valuable text for the physician practising in this field, whether specialist or general practitioner. The list of references at the close of each chapter affords opportunity for further reading of source material. The wealth of illustrations present in this volume is a very important component of any text on obstetrics.

**PHYSICIAN'S HANDBOOK.** (Fourth Edition.) By *John Warkentin, Ph.D., M.D.*, and *Jack D. Lange, M.S., M.D.* *Chicago, Illinois: University Medical Publishers.* 1946. 282 pp. \$1.50.

Reviewed by **ARCHIBALD S. DEMING**

This new edition of this popular and familiar pocket size handbook maintains its characteristic and compact collection of facts and data. It is most practical as a ready reference for necessary details which so easily escape recollection at a moment's notice in subjects which may not be encountered daily in ordinary practice. There are many changes, omissions of obsolete matters and additions of new sections, especially in therapy, with no change in the size of the book.

It is remarkably complete except for the glaring omission of a section on toxicology and antidotes. The laboratory data approaches that of a brief laboratory manual which might better be provided as a laboratory handbook, leaving only

the pertinent facts desired for immediate pocket reference in this Physician's Handbook. The lithograph type is small but satisfactory for short reference work. A few blank pages for personal additional notes would be useful. The index lists many facts under subject groups which may seem elusive until familiarity is gained with groupings.

It is a good handbook for office desk, physician's bag and interne's and resident's pocket. It should pay for itself in convenience very rapidly.

**THE 1946 YEAR BOOK OF OBSTETRICS AND GYNECOLOGY.** Edited by *J. P. Greenhill, B.S., M.D., F.A.C.S.*, Professor of Gynecology, Cook County Graduate School of Medicine; Chairman, Department of Gynecology, Cook County Hospital; Attending Obstetrician and Gynecologist, Michael Reese Hospital; Associate Staff, Chicago Lying-In Hospital; Author of *Office Gynecology* and *Obstetrics in General Practice*; Co-author of the *De Lee-Greenhill Principles and Practice of Obstetrics.* *Chicago: The Year Book Publishers.* 1947. 655 pp. \$3.75.

Reviewed by **STANLEY B. WELD**

This is one of the best Year Books of Obstetrics and Gynecology ever published. In the section on Pregnancy may be found an abstract of Bertha S. Burke's article on Nutrition During Pregnancy published in the *CONNECTICUT STATE MEDICAL JOURNAL*. The material on pelvimetric roentgenology is particularly complete and includes an abstract of Herbert Thoms' article on Outlet Pelvimetry. In the discussion of habitual abortion, as in so many other instances, the editor's remarks are very pertinent. Under Labor the abstracts on anesthesia and ruptured uterus are valuable. It is noticeable that the much heralded caudal anesthesia is being replaced to a large measure by spinal. Thoms and Godfried's Ten Year Survey of Cesarean Section at New Haven Hospital with a maternal mortality of 0.3 per cent may be compared favorably with Irving's Ten Years of Cesarean Section at Boston Lying-In Hospital with a mortality of 1.3 per cent. Ambulatory treatment of obstetrical and gynecological patients has been the subject of several writers. Under the Newborn the discussion of the Rh factor with the editor's comments is worth while reading.

In the section on Gynecology, psychosomatic therapy receives careful consideration and the editor's remarks call attention to the revival of an old method of therapy under a new name. Many pages are devoted to abstracts on infertility and sterility, giving the reader the benefit of the latest thought in this field. Operative technique, infections and benign tumors are well covered. In the latter group of abstracts may be found one of Arthur H. Morse's article on Diagnosis and Treatment of Uterine and Pelvic Endometriosis. The swing toward the use of surgery in cancer of the cervix with the relinquishing of some gynecologists of the use of interstitial implantation of radium is to be noted. A careful study by the general practitioner of the abstracts on menstruation and endocrinology together with the editor's comments should be valuable in producing less experimentation and more thoughtful, scientific therapy.

This volume is commended to all physicians as a valuable ready reference of up-to-date material in the field of obstetrics and gynecology.



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# *The* CONNECTICUT STATE MEDICAL JOURNAL

VOL. XI

AUGUST, 1947

No. 8

## THE SURGICAL TREATMENT OF THROMBOSIS IN THE ARTERIES AND VEINS OF THE LOWER LIMBS

JOHN HOMANS, M.D., *Boston*

The Author. *Surgeon Emeritus, Peter Bent Brigham Hospital*

IN A discussion of thrombosis in the blood vessels of the lower limbs, you will expect me, as a surgeon, to emphasize surgical treatment; and though I am glad to do so, I hope you will not carry away the idea that surgery exclusively employs operative methods. There is, of course, in many instances, a clean-cut distinction between thrombotic occlusion of arteries and of veins. Arterial thrombosis blocks the outflow of blood and threatens the very life of the limb. Venous thrombosis interferes with the return of blood—the drainage system. But there are confusing combinations of arterial and venous occlusion; so that it may be helpful to cover, if only briefly, the whole field. I will take up, then, 1, arterial thrombosis in the elderly, that is, in the presence of arteriosclerosis; 2, combined arterial and venous thrombosis, as in thrombo-angiitis obliterans, and 3, venous thrombosis, that is, the thrombo-embolic problem.

Arterial thrombosis in the elderly, usually arteriosclerotic, individual is the cause of the rather rapid narrowing or actual obstruction which so often brings on the common presenting symptoms of ischemic pain, rubor and even actual gangrene in both men and women of the sixth decade and beyond. I will not trouble you with any pathological distinction between various types of arteriosclerosis. Loss of elasticity in the femoral and smaller arteries interferes with rapid locomotion, slowing down the athlete even in his thirties, but though the process may be progressive, few arteriosclerotics make any

complaint of their legs until a thrombus, or perhaps a series of partly occlusive thrombi, nearly or wholly closes a large artery. And when a large artery is seriously narrowed or plugged, a collateral circulation is no longer, as in youth, readily available. The picturesque and obvious symptom of a deficient arterial flow, intermittent claudication, now sets in. But locomotor troubles are usually followed within a year by even more serious, local signs. The lameness occurs when the great muscles of the calf are unable to secure adequate arterial blood for normal exercise.

The story of intermittent limp is actually very easy to elicit, and it should not be mistaken, as is so often the case, for flatfoot and other causes of painful feet and legs. It is *unilateral*, for the discomfort in the worst leg excludes notice of the other. The pain, or crampy sensation, or disagreeable numbness in the calf appears only on exercise. Walking for a definite distance, at a given pace, always brings it on. Rest relieves it in a few moments, and again, walking calls it back. Perhaps a lowered resistance to cold, and with this, some degree of numbness or a cottony feeling in the soles may be associated with this complex. But the restricted circulation is so likely soon to cause a failure of nutrition in the feet that not many individuals become stabilized, so to speak, short of painful rubor of the toes.

Reddish blue discoloration of one or more toes, especially the big toe, associated with some degree of spontaneous pain, points to a serious arterial deficiency. The rubor and pain are lessened by gentle exercise of the leg in dependency. A prolonged horizontal position, as at night, lessens the rubor, but gradually brings on the pain; for dependency is

*Presented at the 155th Annual Meeting, Connecticut State Medical Society, Hamden, April 29, 1947*

required to fill with arterial blood the stiff, narrowed vessels of the leg, and so the victim must get up at night to hang the foot down. But too much depression, by causing stasis and edema, is as bad as too much elevation, and so life may become almost unendurable. At this point, gangrene is threatened, for minor bruises or even the slight injury due to pressure from a deformed toenail, corn or callous may call in vain for the vigorous blood supply of repair.

Minor degrees of gangrene are rather common. They should not lead to a panicky amputation at the knee or thigh, nor should they coax the unwary surgeon into taking off a toe. For any local operation again demands the vascularity of repair. They should rather set the physician to work at sizing up the situation to discover how he may improve the circulation. He should search for the level at which the main arterial supply is cut down. Palpation of the pulses in the foot, behind the knee, and in the groin, with the aid of such oscillometry as he can get from a anaeroid blood pressure cuff will often rather accurately locate the highest point of occlusion. The common femoral artery will perhaps be open; its continuation below the great profunda branches, closed. Should such be the case and should the toes retain even a faint pinkness on one or two minutes' elevation at  $20^{\circ}$ - $30^{\circ}$ , a collateral circulation is at least potentially present, to be brought out and encouraged by every possible means. On the other hand, if the toes become cadaveric on elevation, and the occlusion is in the popliteal region or below, the chances of securing a collateral circulation are poor. The state of the local sympathetic system is also to be studied. A damp, slightly bluish foot indicates sympathetic irritability and suggests that sympathetic paralysis will secure some vasodilatation in the foot and toes. A dry, cold foot, of which the toes and forepart show rubor and a little edema, offers less encouragement for sympathectomy.

It was my purpose, in offering you this imperfect description, to point out that physiological methods of applying surgery may be very useful, that local amputations are dangerous and that gross amputations are often unnecessary. Before explaining what I mean by physiological surgery, I should remind you that conservative treatment, particularly the abandonment of tobacco, the institution of Buerger's exercises, minute care of the toes and toenails, and such vasodilating drugs, including alcohol, as seem appropriate, should be given. It goes without saying

that the urine and blood should be studied to exclude diabetes, which, if revealed, should adequately be treated.

Surprisingly often, men, and especially heavy smokers, improve under such measures. If they do not, that is, if pain increases and gangrene advances, amputation through the condyles of the femur\* will presumably be required. It is in the fairly wide borderland between these situations, when pain is perhaps barely controlled, rubor of the great and other toes is present, and gangrene is barely held off, that surgery intended to promote vasodilatation is particularly indicated.

An increased blood supply is most readily secured for the foot—where of course it is most needed—because it is here that the constriction-dilatation mechanism, basically related to temperature control of the body, is most active and efficient. Test the state of this system by procaine block of the lumbar sympathetic chain, if you like, but do not expect to learn anything very favorable. Remember that complete removal of sympathetic vaso-constrictive impulses work for 24 hours each day whereas a block† only lasts a few minutes. DeTakats<sup>1</sup> reports very satisfactory results from sympathectomy, even in seemingly unfavorable cases, and my own experience is similar. The color of the toes improves, pain is diminished or abolished; perhaps locomotion becomes more rapid. I have known a man, over 70, whose severe arterial deficiency had come on after a coronary occlusion, who was able to walk so much faster, after sympathectomy, that anginal symptoms returned.

Actually, one may go even farther than sympathectomy. The femoral artery itself may, with benefit, be attacked. If the thrombus is in the upper femoral but distal to the profunda—a common situation—the thrombosed area can perhaps be identified and the vessel resected. If the vein, as well, is included, a little temporary raising of the capillary pressure is added to whatever release of reflex vaso-

\*It should be recognized that venous thrombosis is so often associated with the arteriosclerotic occlusions, that in connection with amputation, the femoral vein should be ligated, to forestall pulmonary embolism. Amputation through the lower leg, save as a guillotine procedure to cut off sepsis (to be followed by a higher amputation) should not even be considered.

†I leave out of consideration the more permanent block by alcohol injection, a matter for a few experts. Very possibly, other locally or generally acting drugs will be developed.



constrictive influences is secured by resetting the irritated artery.\* Thus the combined sympathectomy and resection of the vessels is like the wearing of suspenders with a belt. Those cases, in which I have been able to combine the two, seem to me to have done particularly well. The sympathectomy is, however, the first consideration.

A recent and important addition to the surgeon's armamentarium is McKittrick's amputation close to the distal head of the metatarsals. Its object is to get rid of partly necrotic, functionless, or actually necrotic, toes. The circulation being stabilized and the foot itself fully sound, McKittrick<sup>2</sup> has shown that healing and a functionally useful foot can be secured by this procedure. When amputation of the individual toes would inflict altogether too much injury on tissues unfit for healing, the transmetatarsal transection is apparently well borne.

#### THROMBO-ANGITIS OBLITERANS: ASSOCIATED ARTERIAL AND VENOUS THROMBUS

It is not my purpose to describe this disease in detail. As to its etiology, in relatively young males, I myself accept Thompson's<sup>3</sup> interpretation, at least as a working hypothesis, namely, that it is fundamentally a local disorder of the blood vessels of an allergic nature related to an antigen, often derived from some of the dermatophytes, which is absorbed from the feet.

The arterial obstruction is, of course, of the greater importance, but because veins are more susceptible than arteries to thrombosis, the disease is apt to show itself first in them. A superficial thrombophlebitis, in a migrating, inflammatory form, often precedes all other evidence of the disease and a venous thrombosis deep in the calf may be suspected. But the intermittent claudication of arterial deficiency, persisting, perhaps, for months or years in one leg, is the standard presenting symptom. Other signs may be lacking; so that many individuals are falsely believed to be orthopedic problems. Finally, however, the toes and feet show characteristic changes, or an injury, by calling in vain for the vascularity of repair, occasions gangrene or near-gangrene of one or more toes. Then, rubor, just as in the arteriosclerotic arterial deficiencies, is noticed, and spontaneous pain sets in. There is nothing here essentially different from the discoloration and pain of the arterial disease of older years. Indeed, there

are plenty of borderline cases in the forties and fifties. One need not make a differential diagnosis between arteriosclerosis and Buerger's Disease, and I personally believe that the latter disorder may occur in the aged. Should the x-ray reveal calcified arteries in the affected leg of the older patients, one should undoubtedly expect less than usual from a collateral circulation, but treatment is essentially the same at any age. The really significant differences between arteriosclerotic thrombotic obstruction and that of thrombo-angiitis obliterans are the greater possibility of the establishment of a fine-vessel collateral circulation in the latter and, should local necrosis be imminent, a better chance of safely getting rid of ischemic, gangrene-threatening toes.

The level of obstruction in Buerger's Disease is particularly significant. Obliteration of the upper femoral artery is consistent with an outspoken intermittent claudication and a normal appearance of the foot, even over several years. On the other hand, the involvement of the popliteal artery or of one or more of its great terminal branches—often referred to as the ascending form of the disease—usually leads to the vicious circle of rubor, edema, pain and gangrene which soon calls for amputation of the leg at the knee. Sometimes you will see a warm cyanosis of the foot, associated with spells of pallor and sweating, which points to an unusually inflammatory type of thrombosis, prevailing venous, with a strong vasospastic element, a clearer than usual call for early sympathetic surgery.

As to treatment, let me again point out, what hardly needs emphasis in these days, that the abandonment of tobacco is absolutely imperative. One need not argue patients into complete abstinence. One need only tell them that half-way measures are useless, that persistence inevitably means advance of the disease, and that though improvement, following withdrawal of tobacco, cannot be expected under many months, it will inevitably come. One can assure them, if strong language seems necessary, that, if they continue to smoke, they are utter fools and that they deserve all they subsequently get. In addition, the usual routine exercises, application of fungicides, and care of the toes are of course required, and the intramuscular injection of vasodilating drugs, such as Padutin and Depropanex, should perhaps be employed, but I should like to dwell, even more forcibly than in the management of arteriosclerotic disease, on the value of physiologic surgery and the possibility of getting rid of vulnerable toes. Give your patients six months to try

\*Possibly, centrally travelling sensory impulses, calling forth both local axone reflexes and sympathetic vasospastic responses, mediated by the spinal cord, are abolished.

out the effect of withdrawing tobacco—if their situation permits it—but have in mind a surgical procedure.

I will vouch for the value of direct attack on the femoral artery—in selected cases and following a clinical study—first in a search for the indicated upper level of thrombosis, and then, if that is found, in the form of resection of an inch or two of the thrombosed vessel. In early days, before the surgery of the sympathetic system was developed, I had some enlightening experiences, and Dean Lewis<sup>4</sup> made more than one favorable report of arterial resection. In one instance, that of a bad intermittent claudication and painful rubor of the toes and forefoot, I came upon a thrombosed area in the femoral artery just distal to the profunda, an area which was in process of being canalized. It transmitted a feeble stream and seemed to me to offer a decided lack of encouragement, to say the least, to the formation of a collateral circulation. In any case, its resection, without other treatment, led to a restoration of a normal appearance in the foot and a most astonishing improvement in locomotion. I followed this patient for several years, only finally to lose track of him, so that I cannot answer for the end result in the leg so treated or for the state of the second limb.

Ligation of the common femoral vein as an independent procedure, proximal to the saphenofemoral junction, has been revived of late (Glasser),<sup>5</sup> and by raising venous pressure may benefit the capillary circulation. It is entirely reasonable of course to combine interruption of the femoral vein with resection of the artery.

Sympathectomy is obviously incapable of restoring a circulation through large arteries. The peripheral pulses, once gone, can never be restored. Nor does it, of itself, relieve pain; for the sympathetic is an outflowing vasomotor and sudomotor system. But resection of the lumbar ganglia, especially the first, second and third, removes all vasospastic influences. It certainly encourages the opening up of a collateral system, lessening or actually relieving intermittent claudication. And by releasing constriction of the arterioles and venules, it speeds up the circulation in the toes and feet, promoting healing and presumably lessening edema.

Preliminary procaine lumbar block may well give something of a preview of the results of sympathectomy, but so much is to be expected, even when a rise of temperature in the toes has been absent or minimal, from a total surgical abolition of all

sympathetic impulses, that I, personally, pay very little attention to this observation. However, if one does make a procaine block, one must be so expert in directing the long needle, and so certain of its correct position, that one can correctly interpret the resulting vasodilatation, if any.

Removal of toes, rarely practicable in arteriosclerotic ischemias, may more often be practiced in Buerger's Disease. For soon after the successful weathering of a serious attack, one or more toes may be left stiff, shiny and useless, if not partly destroyed. Local amputations, made with the least possible trauma to the tissues, that is, a minimum of dissection, are often successful. But McKittrick's<sup>2</sup> amputation, through the distal end of the metatarsals, will probably prove more valuable, since it removes at one moment all the highly vulnerable digits. It must never be performed when any part of the foot, as distinguished from the toes, is involved in necrosis or sepsis. My very brief experience of the procedure has given me a high respect for it.

#### THROMBOSIS IN THE VEINS OF THE LOWER LIMBS

Venous thrombosis in the legs, "phlebitis," thrombophlebitis, or what you will, is very much to the fore in these days, and, as is usual in the case of a rather obscure disorder, which has rapidly received more than its share of attention, it has been much misunderstood by physicians and surgeons alike. Some never seem to be aware of it. Others see it when it doesn't exist. Two serious aspects of the disease are evident: the first, pulmonary embolism, the second, post-phlebitic edema, induration and ulceration.

One must assume that venous thrombosis may occur in anyone from youth onward, even in everyday life. But it is especially to be looked for in those over fifty, and in such, is especially likely to cause embolism. Another important consideration is the relation of thrombosis to injury, surgical operation and serious illness, including heart disease. This last aspect has been decidedly neglected. At the Peter Bent Brigham Hospital today only 11 per cent of all fatal pulmonary embolisms are strictly postoperative. Heart disease is probably responsible for more thrombo-embolic episodes than any other.

The pathogenesis of venous thrombosis in the lower limbs is still obscure and even its clinical course is controversial. Since a terminal thrombosis in the veins of the lower legs has been found, when carefully sought, in about 50 per cent of all autopsies,



one is tempted to believe that enfeeblement, bed-life and venous stasis are its chief cause. Yet this hypothesis is far from satisfying. Trauma, in the broad sense, is certainly of great importance. Moreover, nothing fully explains why some thromboses are soft, non-adherent, coagulative processes and others inflammatory, adherent, obstructive ones. Most observers will agree that the two sorts can exist in the same patient—an obvious thrombophlebitis, or phlegmasia alba dolens, in one leg and a quiet phlebothrombosis in the other. Probably Bauer's interpretation, largely based on phlebography, is correct: namely, that quiet "phlebothrombosis," starting below the knees, tends to develop in its final stage into an obstructive thrombophlebitis. This conception implies that cases which do not reach this stage are ended earlier by healing or by death from embolism. To this, I agree. Ochsner,<sup>7</sup> on the other hand, appears to feel that the two states are essentially different and do not merge into one another. In any case, the soft, non-obstructive phlebothrombosis is a frequent cause of pulmonary embolism: the inflammatory thrombophlebitis is not. Yet no one, intentionally, dares to treat the dangerous stage by waiting for its development into the relatively harmless one. Moreover, an extensive process necessarily results in serious after-effects, as both Bauer<sup>8</sup> and I<sup>9</sup> have indicated: For every thrombosis, whether or not obstructive, heals by organization and necessarily cripples the vein's valves. Indeed, Bauer<sup>8</sup> bases what may properly be called the Swedish system of treatment on the prevention, not only of embolism, but of the disabling after-effects of phlegmasia alba dolens, by attempting to limit thrombosis to the region below the knee; that is, preserving the integrity of the valves in the femoral vein. This plan, I am sure, is correct. One should try to halt and heal the quiet, dangerous thromboses early. And, if one encounters the advanced, or thrombophlebitic, stage, one must attack its obstructive and vasospastic side which causes so much crippling edema and ulceration.

*The diagnosis* of thrombosis in its early, quiet, even silent, but dangerous stage is difficult. If a temperature chart is available, a rise of temperature, pulse and respiration usually precedes all other signs. This may actually indicate preclinical pulmonary embolism, for control of the thrombosis, by vein interruption, for example, changes the pictures so rapidly as to suggest that some floating material is suddenly cut off from the venous circulation. Gross pulmonary embolism is pathognomonic unless there

is present such heart disease as may form thrombi in the right auricle. In which case the chances still favor the leg over the right heart as a source. Even if examination of the legs is completely negative, an attack of rapid or difficult breathing, of syncope, of angina-like distress, of right-sided heart embarrassment, otherwise unexplained, and supported perhaps by electrocardiographic signs, point to a probable embolism; and thoracic pain, cough and hemoptysis, backed by roentgenologic evidence of infarction, reveal almost unmistakably an underlying lower leg thrombosis. Moreover, such studies as that recently made by Evans<sup>10</sup> and Boller at the Lahey Clinic, show that in most instances of sudden, unexpected, fatal postoperative pulmonary embolism, recognizable, preliminary warning signs usually precede the killing embolism by many hours or days.

*The Local Signs* in the legs must be sought with especial care. Though pain, if present, is highly suggestive, reliance must be chiefly on evidence of a disturbance among the great posterior muscles of the calf. Measurements often show a slight enlargement. If the two calves are grasped from behind by the examiner's hands, the affected one will feel a little more resilient or even tense than the other; and dorsiflexion of the foot will be ever so slightly resisted by the posterior muscles. Pain on dorsiflexion is a late rather than an early exhibition of what has been called, much against my inclination, Homans's sign. Indeed, if my name is to be involved, it should be related to mere irritability of the great posterior calf muscles. Tenderness is sometimes felt in the course of the thrombosed deep veins, especially on deep pressure over the fibular vessels. Edema and cyanosis are absent, in bed patients, during the early stages of thrombosis. If present, they indicate a process higher than the popliteal space. In other words, they point to involvement of the femoral vein, a most important consideration in treatment. Any superficial thrombosis, especially in veins not grossly varicose, is apt to be secondary to a deeper process. A short pencil-like hardened vein on the back of the calf may be pathognomonic. In general, all symptoms and signs, in bed patients, lag far behind the progress of the disease: whereas in the ambulatory they indicate rather accurately its actual extent.

#### TREATMENT

Let me repeat the two parts of the problem: to prevent or stop pulmonary embolism; to prevent or minimize post-phlebitic edema, induration and ulcer-

ation. Obviously, prevention, that is, prophylactic measures, should be considered first.

*Prophylactic Treatment* must be applied on so very large a scale to reach the occasional patient who, without it, would have suffered thrombosis, that it had better be limited to the group most liable to thrombosis, namely, patients over 50 years of age, who are undergoing major operations upon the abdomen, pelvis and thorax, or are to be treated for fractures of the lower limbs and pelvis. To these might well be added those suffering from such cardiac disorders as coronary occlusion and acute decompensation. The background of all prophylaxis is of course the preservation, so far as possible, of the normal circulatory physiology—in respect to fluid balance and the state of the blood—the avoidance of trauma, and the attainment, not so much of early ambulation, as of active exercise of the lower limbs and avoidance of the reclining or sitting position during confinement to bed. Prophylactic administration of anticoagulants should be used *only when adequate blood studies are available*, and especially when the conditions likely to cause thrombo-embolism will be of brief duration. Dicumarol is favored because of its cheapness and ease of administration, and in spite of its somewhat unpredictable control of prothrombin formation by the liver. Obviously, it cannot be started for a day or two after an operation, especially when the operative field is extensive. The attempt is made to secure a level of 20-30 per cent of prothrombin in the blood.\* An advantage of this drug is that the "tapering off" period is prolonged after the last dose and while the patient is becoming fully ambulatory. Heparin is less satisfactory prophylactically because of its expense, which usually runs to more than \$10 a day, even if it is given in divided doses intravenously (see below) but Evans indorses its brief use in Pitkin's menstruum, as proposed and practiced by Loewe.<sup>11</sup> I shall briefly consider this method presently under "definitive treatment," and I shall not trouble you with the contraindications. My primary object is to give you a picture of operative treatment.

*Prophylactic Bilateral Superficial Femoral Vein Division*, that is, distal to the profunda, as developed at the Massachusetts General Hospital, has much to recommend it. Dr. A. W. Allen, Dr. Linton and

their associates\* have devoted it to their bad-risk patients, chiefly of 65 years and older. In connection with such operations as gastrectomy, resection of the bowel for cancer, prostatectomy and malignant uterine disease, and as an integral part of the treatment of fractures near the hip, bilateral femoral vein ligation has been performed on some 600 patients, with one death from subsequent embolism. The ligations were sometimes performed at the end of the major procedure and at other times, under procaine infiltration two days later. A few prophylactic ligations were also performed for "decompensated heart disease." There were no accidents from the operation itself. Clearly the results have been excellent, but I believe that only in the hands of equally skillful, practiced surgeons can the operation be justified.

#### DEFINITIVE TREATMENT OF ESTABLISHED VENOUS THROMBOSIS

Obviously, if surgical interruption of the great vein of the leg could end all danger of pulmonary embolism, it would have an advantage over chemical methods, which require accurate laboratory control and which are effective only during the administration of the drug. But I am asking you to adopt the viewpoint that, even under ideal conditions, vein interruption cannot score 100 per cent successes—the reasons for which will incidentally appear—and, similarly, the use of anticoagulants is subject to a number of inherent defects. And since statistical evidence must still require years of study, I am going to indicate briefly the conditions under which one system or the other appears to offer special advantages and the extent of the debatable ground.

#### INTERRUPTION OF VEINS

In individuals of 50 years and beyond, when embolism has occurred, whether or not signs of thrombosis in one or both legs are present, bilateral femoral vein ligation, proximal to the profunda, has more authority in preventing further embolism from the lower limbs than have the anticoagulants. Section of the femorals *distal* to the profunda system does not fully prevent embolism or the extension of thrombosis into the common femoral and iliac veins, and indeed may rarely seem to hasten both events. But interruption of the common femoral, especially when the thrombotic process is attacked so early

\*Undoubtedly, when given prophylactically, dicumarol can be administered successfully in much smaller doses, by contrast with those required when thrombosis is established and the patient is definitely thrombophilic.

\*In a section below, reference is made to the actual publications, including those of the gynecological service; and a comparison is offered with the statistics of those who have used prophylactic anticoagulant therapy.



that it has not yet reached the groin, cuts off the threat of embolism from the legs. It can have no effect, of course, on the rare thromboses which start in the pelvic veins.

As thrombosis advances, embolism continuing or being expected, bilateral common femoral interruption will now require extraction of soft clot or even an older obstructing thrombus by suction. The blood will presumably have become increasingly thrombophilic, so that anticoagulants may usefully supplement operative interruption. Operation forestalls many of the reflex vasoconstrictions of obstructive thrombophlebitis, should that be setting in, but since the femoral bottleneck is, in any case, left closed, great care in restoring ambulation is required, and some edema of one or both legs must necessarily follow. This is indeed the bane of femoral vein ligation. For though all advanced thromboses, whether or not obstructive, leave the femoral system disabled under both surgery and anticoagulants, common femoral closure, on top of an extensive thrombosis, is especially crippling, and may even trap so much blood in the affected limb as to cause some degree of immediate, postoperative shock.

When embolism has not occurred, under the conditions just outlined, but a diagnosis of thrombosis is made, the age of the process is important, as is indicated in the three paragraphs immediately following:

*Early processes*, still confined to the lower leg, require special consideration. My first<sup>12</sup> experiences were with these, especially in ambulatory patients. Before the days of anticoagulants, femoral vein ligation was clearly the only way to prevent embolism, and seemed to have a very favorable effect upon the thrombosis itself. For though elevation of the leg (with exercise) in bed, without any other specific treatment, always seemed to halt it, recurrence and even aggravation of symptoms usually followed return to active life. Many unilateral superficial femoral vein interruptions were successfully performed. However, later experience showed that some of these early thromboses were bilateral, and that, in others, strictly unilateral, the thrombosis either passed into the profunda system from below and emerged above the ligature, or had started simultaneously in the deep muscular veins of the thigh. Thus bilateral common femoral vein interruption, to cover these exceptional happenings, was clearly needed. This procedure seemed to me unnecessarily radical and disabling under the circumstances. Therefore, I have since substituted the anti-

coagulants, especially dicumarol. I believe that they are as effective as surgery in preventing embolism from early thrombosis. And I feel sure that by limiting the extension of thrombosis into the femoral system, they are, as Bauer<sup>13</sup> maintains, superior to any treatment which leaves the femoral vein functionless or obstructed.

*Thrombosis which has occurred as a complication of two-stage procedures*, such as those used for intestinal cancer and for prostatism, should be controlled by vein interruption. Perhaps, indeed, prophylactic vein ligation should precede all such operations.

*Thrombophlebitis*, the late obstructive inflammatory stage of thrombosis, requires special treatment aimed at its vasospastic side. The widespread peripheral constriction of the smallest blood vessels, which increases edema by disorganizing the fluid exchange in the capillary bed, is believed to be a reflex phenomenon, the sympathetic nerve supply to the affected leg being overstimulated. Dramatic relief of the slightly cyanotic swelling usually follows a lumbar sympathetic procaine block, as both Leriche<sup>14</sup> and Kunlin, and Ochsner<sup>15</sup> and DeBakey have indicated. At the same time, any constriction of the larger arteries, presumed to be a related affair, tends to be relaxed. Several blocks may be required. Such pain and cutaneous paresthesia as may be present are relieved as well. It has been observed that in the early days of an established thrombophlebitis, opening the femoral vein and removing the thrombus has a similar effect, but unless there is some other reason for thrombectomy, the operation should not be used. Attention should rather be given to the second leg, which may be the seat of a phlebotrombosis, requiring treatment by either anticoagulants or femoral vein ligation. If means of treating thrombophlebitis by sympathetic block are not available, elevation of the limb in bed, with as much exercise as possible, should be employed. Warming the body should promote vasodilatation. When the patient is able to get up, active exercise in a dependent position must be alternated with elevation of the limb, to promote mechanical drainage of blood and lymph.

*Persistent or Recurring Thrombosis*, especially if associated with pulmonary embolism, which may have simulated cardiac disease, is the most clean-cut indication for vein interruption; for the condition is continuing and must be altered. However, if both legs are involved, the selection of a level for ligation

is difficult. If the common femoral level—proximal to the profunda—is selected, serious venous congestion and edema will almost certainly follow. If the ligation is made distal to the profunda, little, if any, additional venous stasis results, but immediate and future thrombo-embolism is still possible. Here superficial femoral vein interruption and anticoagulant therapy may usefully be combined—a matter too little realized. The use of vena caval ligation for persistent or recurring bilateral processes will presently be discussed.

If the persistent or recurring thrombosis is unilateral, the ideal treatment is *common iliac vein interruption*. This higher ligation is preferred because of the very satisfactory collateral circulation at the common iliac level, and because of its clean-cut authority. Its only disadvantage is that it is more difficult to perform, especially on the left. A general anesthesia is required. I fully described the procedure<sup>16,17</sup> in 1943-44.

*Vena caval ligation* should be used only when thrombo-embolism appears otherwise uncontrollable, as, for example, when an immediate end of embolism is imperative, when persistent bilateral thrombosis with embolism is established, or when the source of embolism, though presumed to lie in the pelvis or legs, cannot be identified. If used, it must be followed immediately by high elevation of the legs and by a carefully governed convalescence. Vena caval ligation should so be performed that a good anterior view of the great vein is had. For its entering lateral branches may easily be torn if a ligature-carrying instrument is passed blindly about it. A right transverse incision at the umbilical level, with combined section and splitting of the oblique muscles, offers a good retroperitoneal but still anterior approach (Thebault and Ward).<sup>18</sup> A transperitoneal approach is, of course, more disturbing to the patient, but must be used when it is planned to include the ovarian veins.

#### STATISTICAL STUDIES

Before drawing conclusions, I should like to say a word about statistical studies. These suffer from three defects: 1. They are almost entirely devoted to postoperative thrombo-embolism (only perhaps 10-15 per cent of all fatal embolism being of this nature); 2. They take little or no cognizance of its age incidence; and 3. They assume that all hospital populations and clinics are alike; whereas some actually are chiefly surgical, or serve a very mixed urban population and so on. With these qualifications, the figures—principally Swedish—offered by Zilliacus<sup>19</sup> and Jorpes<sup>20</sup> show how profoundly heparin treatment, devoted to already diagnosed

thrombosis, has lowered its morbidity and mortality. If, as a control for assaying the value of vein interruption and anticoagulants, we accept 1-2 per cent as the incidence of thrombosis (chiefly postoperative), 50 per cent as the incidence of embolism and 20 per cent as the incidence of fatal embolism from such thromboses, we shall not be far wrong. Following childbirth, we may accept percentages of about one-third of these figures for thrombosis, and one-fifth for fatal embolism. Since Bauer<sup>13</sup> has used heparin, *after making a positive diagnosis of thrombosis*, he has noted a drop in fatal embolism (1940-1945) from about 20 per cent to 1.4 per cent. Bauer calls particular attention to the short hospital stay under this system and the prevention of extension upwards into the femoral vein, by which post-phlebitic complications are greatly reduced in number.

Against such a background, I will not attempt to offer statistical evidence in favor of vein interruption. For one thing, no large figures are available. For another, ligations are usually reported as dealing chiefly with the older age group. However, the various figures of Allen,<sup>21,22</sup> Linton and Donaldson from the Massachusetts General Hospital are decidedly interesting. Up to June, 1944, in 464 cases, chiefly postoperative, but including some serious cardiacs (which other series neglect), the authors find that no deaths "have occurred as the result of femoral vein interruption." Among the 23 deaths attributed by them to the underlying disease, there were, however, four instances of new embolism following ligation, as proved by autopsy. In only one of these (fatal dermatomyositis) had bilateral common femoral interruption been performed. In the other three, all cardiacs, the ligation was either unilateral or of the superficial femoral only.

In their publication of 1947, the same authors carry forward their observations. Among 1300 patients treated by both prophylactic and definitive vein interruption—including the gynecological (Meigs<sup>23</sup> et al) and genito-urinary services—6 deaths were attributable to subsequent pulmonary embolism. Of these deaths, one followed prophylactic vein division, and in this, the autopsy disclosed a stretch of several centimeters of thrombosed femoral vein between the ligature and the profunda branch above. To this technical accident the fatal embolism is attributed. Of the 5 other fatalities, all of which followed vein interruptions for actual thrombo-embolism, 4 have just been discussed and one more is added.

*Prophylactic bilateral superficial femoral vein division* is separately discussed by the same authors. Among 529 patients so treated, of whom 458 were 65 or more years of age, one death from embolism occurred (described in the previous paragraph). Allen<sup>24</sup> (1947) presents as well a very instructive Table in which these 458 prophylactically treated cases are compared, case for case, with an identical number of untreated controls—5 thromboses and one fatal embolism, against 55 thromboses and 26 fatal embolisms in the control series. For further comparison, several accounts of prophylactic anticoagulant therapy are available. At the Mayo Clinic, Barker<sup>25</sup> et al include a group of 438 patients prophylactically treated with dicumarol after abdominal hysterectomy (age not stated) among their 1000 miscellaneous postoperative surgical cases subjected to both prophylactic and definitive treatment. No deaths occurred and only one or two thromboses. Crafoord,<sup>26</sup> in Sweden, offers 325 major



surgical cases, of 35 years and over, in which prophylactic heparin was used, without a fatality from pulmonary embolism and only 3 suspected thromboses; and Murray<sup>27</sup> lists 40 postoperative major surgical cases, successfully treated prophylactically with heparin. All such reports appear, if anything, to favor prophylactic anticoagulant therapy. But how such therapy will compare with vein interruption, if applied to a group comparable with that treated by Allen and his associates at the Massachusetts General Hospital is a matter yet to be settled.

Finally, in some clinics, vein interruptions have been used rather freely for thrombo-embolism in medical cases, a difficult field almost ignored in present day statistics, as just presented. It is in this last field, one in which the cause of thromboses is present over a long period, and which, therefore, is rather inappropriate for anticoagulant therapy, that vein interruption has been called on to perform a most difficult task as to which little is as yet known. Thus, for various reasons, completely parallel studies of the results of the two systems have not been made and perhaps never can be made.

#### SUMMARY

Prophylactic bilateral superficial femoral vein interruption, if expertly performed, is useful in the prevention of thrombo-embolism among elderly patients subjected to serious operations and certain fractures of the upper femur. Its relative value as compared with the prophylactic use of anticoagulants is not yet known.

Definitive treatment by bilateral common femoral vein interruption should be preferred for patients of 50 years and over:

(1) To stop, or prevent, embolism from established thrombosis in the lower limbs, when conditions causing thrombosis are continuing, especially in two-stage surgical procedures or necessarily prolonged confinement to bed, as by some hip fractures and disabling diseases.

(2) When anticoagulants, whether or not otherwise preferable, are unavailable or contraindicated.

Unilateral common iliac vein interruption is preferred for persistent or recurrent unilateral thromboses, whether or not embolism has occurred.

Vena caval ligation is indicated to prevent immediately threatened death from embolism in pelvic thromboses and those presumed to be present in one or both lower limbs. It is also indicated for old, advanced, bilateral, lower-limb thrombo-embolic processes.

Vein interruption and anticoagulant therapy can undoubtedly be made to supplement each other in one clinic, and even, in selected cases, in one patient.

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## THE THERAPEUTIC USE AND THE HAZARDS OF BED REST

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WHEN a patient lies flat in bed he has a flow of blood through the lungs and the tissues of the body 15 to 40 per cent greater than when he is sitting in a chair or propped up in bed in the orthopneic position.<sup>1</sup> Lying flat, the pressure in the veins of the legs is low and the caliber correspondingly small. As the volume flow increases, rather than decreases, on lying down, and the velocity of flow, at a given volume flow, varies inversely as the square of the radius of the vein, it is obvious that there will be a considerable increase in velocity of blood flow in the legs when lying fully recumbent, and a decrease in the tendency to propagation of thrombi.

To keep a patient propped up in bed it is usually necessary to elevate the knees, and pressure per square inch is very heavy on a few points in the buttocks, calves and heels. There is also little opportunity to roll from side to side, so that pressure is maintained for hours at a time. This leads to ischemic injury of the skin and of deeper tissues. Long before bed sores form, thrombi develop in the small veins in these regions, and it is these which lead to phlebothrombosis of the great veins of the legs.<sup>2</sup> When patients lie flat their weight is more evenly distributed, and they constantly roll about unless in stupor or under heavy sedation. Thus the risks of initiating

and propagating thrombi are less in absolute recumbency than when patients are propped up in bed. Because the orthopneic or Fowler position offer greater hazards than recumbency, and is less restful than sitting in an armchair, it is preferable to let patients sit up and move from bed when they do not need the recumbent position for a definite therapeutic purpose.

Absolute recumbency is essential in shock, either medical or surgical, and usually some elevation of the foot of the bed is desirable in these cases in order to assure maximal venous return from the abdomen and legs. Some febrile patients are so weak that they are most comfortable if recumbent day and night. Reasons for believing that recumbency is of value in treatment of apical tuberculosis<sup>3</sup> will be presented again in this paper. Recumbency for most of the 24 hours may also be helpful after laparotomy, hernia repair, or childbirth. There is no reason why these patients should not be in chairs if they are permitted to be propped up in bed to eat, read or chat with visitors.

The Valsalva experiment—bearing down with the breath held in inspiration—puts a greater strain on the heart, the veins, and the belly-wall than does the erect posture or walking on the level. As the intrathoracic pressure rises, venous return to the heart ceases and arterial pressure falls. When the breath is released the dammed back blood surges into the heart and blood pressure and stroke volume rise



above resting levels. The changes in pulse rate and blood pressure due to use of a bed pan, or even of the urinal in the case of old men, are greater than those due to slowly rising and moving to and from a nearby commode. For this reason we encourage older patients with coronary occlusion to sit up as soon as they are safely out of shock. In congestive heart failure, orthopnea makes prolonged recumbency impossible, so that sitting in a chair may be permitted from the start of therapy. While sitting up does reduce the work of the heart and decreases pulmonary congestion, it also decreases diuresis and the rate of return of blood volume to normal. Hence the cardiac should be encouraged, as recovery sets in, to rest in bed as nearly recumbent as possible for intervals throughout the day. Once they are able to sleep flat it is usually found that the tendency to nocturnal dyspnea is less if they rest for an hour or two in the middle of the day, as this causes a redistribution of blood, and diuresis.

Uninterrupted bed rest, in any position or combination of positions not only interferes with digestion, predisposes to constipation, causes loss of muscular and vasomotor tone, and lowers the morale and alertness of patients, but it predisposes them to pulmonary collapse and basal pneumonia. The coughing spells due to these complications, or the straining at stool, are the usual causes of break-down in laparotomy wounds. Severe injury or illness have been shown to affect endocrine function and lead to wasting of calcium from bones and nitrogen from the protein stores of the body.<sup>4</sup> Prolonged immobility accentuates these changes. For all these conditions, prevention is far more desirable than any form of treatment. Minimal sedation, absolute recumbency with frequent change of position, and the earliest possible ambulation are the most effective prophylactic measures. When patients feel they would like to sit up and move about the room, this rarely should be forbidden completely for days or weeks. When the morning temperatures are normal and the pulse satisfactory, patients usually should be encouraged to sit up for meals and elimination, even though they tire and are glad to resume complete recumbency in a few minutes. Any patient who is being propped up for many hours a day, to read, would be better off if encouraged to move to and from his armchair. Digestion, circulation and sleep are improved by alternating recumbency with walking and sitting. Nursing is thus simplified and convalescence shortened.

In one chronic disease, prolonged recumbency is of proved therapeutic value. Active apical tuberculosis, especially in the early stages when the patient feels no inclination to rest, responds to bed rest better than to any other therapy at our command. Here it is wise to keep the patient flat in bed, on back, side or belly but favoring the affected side. In these cases however it is preferable to allow patients to sit up for meals and to use a nearby bathroom except when fever causes prostration.

Adult tuberculosis usually begins at the apical zone, and progresses in that region when the rest of the lung resists infection in spite of months or years of positive sputum. In cattle and rabbits, on the other hand, the parts of the lung nearest the diaphragm, close to the spine, have the poorest resistance.<sup>5</sup> These postural effects can now be ascribed to the relatively inadequate blood flow and lymph formation in the parts of the lungs farthest above the heart in the gravitational field.<sup>3</sup> In rabbits, Medlar and Sasano found that the site of progressive lesions could be shifted from the juxta-diaphragmatic region to the apices by keeping the animals erect in harness eleven hours a day.<sup>6</sup>

The pressure in the pulmonary arterial system of erect inactive people is less than the hydrostatic pressure of a column of blood extending from the right ventricle to the upper third of the lung. The right pulmonary artery is long and tortuous, so that pressure must be lower on this side, which is known to be the more common site of the initial active apical lesion. In cases of pulmonic stenosis the apical ischemia must be more marked than in normals, and an unusually high incidence of progressive apical tuberculosis has been recorded in these cases.<sup>7</sup> In mitral stenosis pulmonic arterial pressure is two to six times normal, and active apical disease is remarkably rare.<sup>8</sup>

When pulmonary flow ceases because of posture the alveolar aeration continues, and oxygen tension rises, carbon dioxide tension falls, since venous blood from the right heart no longer is present. These changes favor growth of tubercle bacilli.<sup>9</sup> Toxins accumulate rapidly because no longer diluted or washed away by blood or lymph. Antibody levels fall for the same reason. It therefore is not strange that adults who are erect for many hours each day are prone to apical tuberculosis, and that complete recumbency, long advocated by Pratt of Boston,<sup>10</sup> restores to the apices the same resistance as is normally shown by the lower two-thirds of the lungs.

Obviously, sitting up in bed for several hours a day can reduce the value of rest treatment in this condition.

Much of our present hospital practice crystallized in wards full of typhoid fever and septic wounds at the time when Florence Nightingale was raising nursing to a skilled profession. Our high hospital beds came later, and simplified the care of bed-fast patients. They are awkward for those who should be alternately in bed and in a chair. Thomas Lewis introduced an ideal bed for such cases, one in which the patient, with no effort on his part, can be elevated from complete recumbency to sitting up straight with his feet only an inch or two from the floor. This is rarely available in American hospitals. A low bed and an armchair are ideal for most patients during most of the illnesses for which we prescribe rest.

Our care of pulmonary tuberculosis is based on traditions going back to Trudeau, a lover of the wilderness whose disease was retarded by a life combining recumbency and mild daily activity in the region where he felt most at home. Sanatoria in regions of low land value can reduce the cost of chronic hospital care, if costs of transportation are reasonable. The tubercle bacillus counts of the air about open cases of tuberculosis will fall if they are kept in vigorously ventilated wards or open porches exposed to the sun. This will reduce the hazard to attendants and to those with closed lesions. Wind and glare also interfere with reading and tend to keep patients recumbent during the day. Whether life in an isolated sanatorium raises or lowers morale will vary greatly with the personality of each patient and with those of the staff and patients with whom he lives. In any event, fresh air, rural surroundings, or a few thousand feet change in altitude have no more beneficial effect on pulmonary tuberculosis than the sarsaparilla which Vesalius considered a cure for syphilis, or the tartar emetic which Laennec thought a specific for pneumonia. Recumbency and collapse therapy are rational therapeutic agents of proved efficacy.

For many patients in whom tuberculosis is detected early the ideal therapy is confinement at home

in a room with oiled floor and bedding, open windows most of the day, and a closed door. Here the patient can remain recumbent, cared for by people whose exposure was far greater prior to diagnosis than it ever will be after isolation and proper precautions are instituted. Such patients can usually use the bathroom and sit up for meals. Once a month they may be up for a few hours to go for roentgen study. As recovery progresses the time out of bed can be increased, but for months after healing seen complete rest in the recumbent posture at midday and in the evening is advisable.

#### SUMMARY

Physicians and surgeons have been scrutinizing the therapeutic value and the risks of bed rest. Time honored procedures have been altered as a result of seeking correct physiological methods of managing patients after operation and during various types of illness. Today the physician must ask himself "What bed rest of value at this stage of the management of this case? Has it been ordered from force of habit or for sound physiologic reasons? How many hours a day should this patient lie flat in bed? When not flat in bed is it best for him to be moved to a chair or to walk about the room, or do the advantages of propping him up on pillows outweigh the hazards of that position?" Correctly answering these queries in every case, will speed recovery, and lower mortality.

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## EARLY AMBULATION IN CONJUNCTION WITH THE USE OF THE METALLIC SUTURE

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MOST OF US are aware of the fact that early ambulation in surgery is not new, since it was practiced as long ago as 1896. But it was not until World War II that this method of postoperative care received its greatest impetus. The need for turning personnel to the job at the very earliest date, inadequate nursing facilities, and too few hospital beds, made early ambulation a must in certain theaters of the recent world conflict. A great deal has been written on this subject, particularly during the past five years, and the American College of Surgeons considered it important enough to devote a panel discussion to this phase of the surgical conference at its recent convention in Cleveland.

Similarly, use of the metallic suture is hardly an innovation in surgical practice. Personal experience with early ambulation happened to be coincidental with the use of the metallic suture, and since neither of these procedures are in universal use by general surgeons it seems worthwhile to comment briefly on the advantages and drawbacks of this combination.

After listening and talking to surgeons of far greater experience than mine, and reading of the results of early ambulation in some of the large teaching hospitals, plus the results in our own small series of cases, I must confess that I am nearly as enthusiastic as the Cleveland news man, who, in reporting the panel discussion on Early Ambulation at the recent convention of the American College of Surgeons, headlined his article: "Bed Rest Following Surgery is Harmful."

There can be little question but that the patient out of bed twenty-four hours after a major operation has a great deal to be grateful for. Because of the fact that his skeletal muscles are actually functioning, the usual weakness complained of by most patients after seven to ten days in bed is virtually absent. As a result of his physical activity, his bowel

function is better, discomfort from distension not as marked, and enemata less frequent. With improved bowel elimination it is possible to place him on a diet with adequate protein content to insure wound healing. In our series, where spinal anesthesia has been used, a regular diet is started the evening of the day of operation, and otherwise the following day. Age should play no part when early rising is considered. Again, in our own group, ages varied from four to sixty-four. The type of operative procedure should likewise play little part as to whether the patient is to rise early. In our own experience, resections of the colon with drainage did just as well as the relatively simple inguinal herniae, cesarean sections, and cholecystectomies.

Early rising patients require, on the average, fewer narcotics. Thrombo-phlebitis, phlebo-thrombosis, and embolic phenomena are usually less frequent in most large series reported. At the recent sectional meeting of the College of Surgeons held in Providence in March of this year, it was reported from the Peter Bent Brigham Hospital in Boston that early ambulation had been used for surgical patients since 1942. In their series of several hundred cases the incidence of blood vessel pathology and embolic phenomena was approximately the same as in a comparative series of cases kept in bed the customary length of time. In spite of this finding, instead of deterring them in the use of early ambulation, they are carrying on with this type of therapy, and, in fact, are now getting their patients up on the day of operation whenever feasible. Our own series of cases is relatively modest, since the total is but eighty-five. Yet in this group, which dates back to September 1946, there have been no instances of blood vessel pathology or embolic phenomena.

Pulmonary complications seem to be somewhat lessened, and finally the patient profits financially. His hospital stay is shorter, the average for our

patients being six to seven days, where previously it was ten to twelve days. Because he is back at work at an earlier date, his pocketbook benefits all the more.

A discussion of early ambulation would hardly be complete without reference to the incision. What is the incidence of disruption and of postoperative herniation? We have probably been fortunate in our own experience, for we have not had one dehiscence, nor to my knowledge any late herniation. The use of the metallic suture may possibly have been a factor. Writers on early ambulation reporting large series of cases do cite instances of immediate and delayed herniation of wounds, but the incidence is apparently no higher than when prolonged bed rest is utilized.

A word should be said too of the advantage to the hospital and nursing personnel of the early ambulant patient. Hospital beds throughout the country are at a premium, and it seems quite obvious that with the shorter stay of the early rising patient this difficult situation is relieved to some degree. And then, of course, the amount of bedside nursing care required by this type of patient is infinitely less, and for this the institutional nurse is extremely grateful.

What are the contraindications for early ambulation? As far as I have been able to determine there are but two: generalized peritonitis, and certain medical complications, such as cardiac decompensation and pneumonia, when the patient would not be permitted up anyway.

We have found no disadvantage to early ambulation following major surgery, and though I have heard several discussions on this subject by eminent surgeons, I have yet to hear anyone who has utilized this type of therapy speak of its bad features.

The technique of early ambulation is relatively simple. On the day of operation, or twenty-four hours after operation, the patient is turned on his side, preferably on the operative side, the knees are flexed on the abdomen, and with the aid of his nurse the legs are swung off the bed and the patient brought to a sitting position. (A binder may or may not be used on the abdomen. In our own series we have used it not because we were fearful of the wound, but simply that it was more comfortable for the patient.) The patient then slides to the floor and is immediately encouraged to walk and not sit. Sitting encourages venous stasis in the pelvis and extremities. The patient is encouraged to repeat the

performance not once, but two or three times the first day. After the initial venture there is little difficulty getting the patient to repeat exercise in increasing amounts during the remainder of his hospital stay. Our biggest problem is oftentimes with the nurse, who insists on sitting the patient in a chair instead of encouraging her charge in the all important exercise of walking.

In the beginning we anticipated that the patient would complain bitterly of pain at the operative site. But such is not the case. They do say that the wound is sore, but one gets the impression that the patient is undergoing very little more discomfort than when lying in bed.

I should like to conclude with a few words on the use of the metallic suture in wound closure. As stated previously, personal experience with early ambulation was coincidental with the use of this type of suture, but I do not wish to give the impression that such suture material is essential to early rising postoperatively. Such is far from the case though most writers agree that a non-absorbable suture such as silk, silk nylon, or cotton is desirable.

My experience with the metallic suture has been principally with a wire alloy perfected by Dr. Wayne Babcock of Temple University. Its tensile strength is high. It is extremely malleable, so the square knots can be tied without breakage at the knot. Tissue reaction about the suture is nil. Wound examined five to seven days postoperatively show none of the localized edema usually encountered in wounds closed with cat gut. It may be used without qualm in the presence of infection. It is manufactured in a variety of sizes, from the very fine hairlike wire for ligature, to the heavier gauge for fascia. It has the added advantage of being infinitely cheaper than catgut and can, of course, be resterilized as often as desired.

To the surgeon accustomed to the use of catgut the metallic suture is, at first, somewhat difficult to handle, but after experience this minor disadvantage is largely overcome.

To offset the disadvantage of handling metallic sutures, one of the prominent suture manufacturing houses has developed a braided wire tantalum suture material. Tissue reaction to tantalum is practically negligible. There can be no question that the product is more pliable, but in our experience we have found that it does not have quite the tensile strength at the knot as compared with the Babcock



wire, and it has the added disadvantage of being more expensive.

In wound closure the wire suture is used in all layers, with the exception of the peritoneum—interrupted sutures placed approximately one centimeter apart. Square knots are essential, and the wire is cut exactly at the knot.

In our hands, the combination of early ambulation in conjunction with the use of the metallic suture has worked out remarkably well in a relatively small series of cases. In fact, our results to date have been so satisfactory that we propose to continue with this combination until such time as further developments in surgical technique should warrant a change.

## EARLY AMBULATION

CLINTON D. DEMING, M.D., *Hartford*

OUTSTANDING men in the past have been strong advocates of complete bed rest for patients. John Hunter regarded rest "as the most powerful aid which the surgeon could bring to the aid of disordered tissues." The attitude of such men was influenced by the prevalence of more tuberculosis and other chronic infections which required rest and which occur less frequently today. However, today many of our medical men and surgeons still hold to the old idea of complete rest in bed. To my amazement I could find no great medical man who has gone out as a champion for early ambulation, although I have reviewed an abundance of literature, all of which gives favorable statistics on the subject. Psychiatrists no longer advocate complete bed rest. Cardiologists get their cases of congestive heart failure, angina, and even coronary occlusion out of bed much earlier than they used to. As for orthopedics, in 1931 Smith-Petersen invented a nail for fracture of the femur, and fusion operations for fixation of the spine, both improvements brought about in order that the orthopedic surgeons may get their patients out of bed and prevent complications caused by prolonged periods of recumbency. Pediatric patients cannot be kept recumbent even post-operatively, and we rarely see a recurrent hernia in a child. Everyone agrees that the aged should not be kept recumbent. If this be true, why shouldn't the advocacy of early ambulation in those ages between the very old and the very young be favored.

In spite of the fact that the medical literature (mainly European) contains reports of many thousands of favorable cases, it is only in the past few

years that any significant amount of attention has been given to the subject in this country. This seeming paradox exists because early rising of patients after operation is the exact contradiction to one of the most deeply rooted principles of patient care.

Early rising is not a substitution but an adjunct to the generally accepted and proven features of surgical technique and pre- and postoperative care. Indeed, early ambulation is now possible only because of such improvements in surgical technique.

Emil Reis of Chicago is given credit as being the first advocate of early ambulation in this country. That was in 1899, but very little enthusiasm on the subject was shown until the 1940's. Kimbarovskiy (M. A. and Bernard) in 1940 did some very interesting experimental work on dogs. After laparotomy and stomach incisions with half the dogs restrained and the other half ambulatory, microscopic sections of the tissues were made on the 5th, 7th, and 9th days. The stomach incisions healed alike in each group, whereas the ambulatory group showed definitely more rapid resolution of fibrin and more rapid organization of fibrous tissue and healing in the dogs who were mobile. They claimed that this was due to improvement in general circulation and in the circulation of local wound areas. Newburger in 1943 confirmed these experiments.

Leithauser has shown that after abdominal surgery with early rising the vital capacity of the lung apparatus becomes normal in half the time that it takes when the patient remains recumbent. This work was confirmed by Churchill (1927) and Cutler

of Boston, who also state that 50 per cent of pulmonary complications of primary importance are established in the first 24 hours and 90 per cent before the end of the 4th day. As regards pulmonary complications, Dr. Kimbarovskiy reported 1,600 major operations with an incidence of thrombosis and embolus of only 0.2 per cent. L. Zava (1940) reported on six thousand major cases of early ambulation without a single death from pulmonary embolism and all reports in the literature state that the incidence of phlebitis and embolism is reduced ten times (0.1 per cent) as compared with the recumbent cases. In 20,000 cases from reports in the literature I could find only 5 cases of fatal pulmonary embolus. (That is 0.025 per cent.) The literature up to now reports no increase in percentage of recurrence due to early rising following hernia operations. Practically all authors who have used early ambulation report favorably and encourage its use in herniorrhaphies. The claim is valid that sutures are fully as strong on the first day postoperative as they are on the eighth or ninth day. Dahl reported on 110 cases of hernia upon the first day, with a recurrence of only 2.7 per cent in a two year follow-up. There are several reports from the Army service of hundreds of cases without any recurrences, but the follow-up was only for six weeks. The Surgeon General in 1943 gave out a directive discontinuing the policy of early ambulation in the treatment of inguinal herniae. He, however, gave no statistics on the subject. My own experience has been favorable, particularly with the use of fascia suture in weak spots. The great majority of my cases walk to the bathroom on the first day and, almost without exception, they walk not later than the third day. I believe that recurrences following herniorrhaphies are not caused by voluntary muscular movement, such as used in early rising, but by involuntary muscular movements, such as repeated coughing and sneezing.

The literature is filled with favorable reports on early ambulation in major surgical cases, such as stomach, gall bladder, and combined abdominal and pelvic operations. These cases also show fewer vascular and pulmonary complications than those that are kept recumbent and the incidence of pulmonary embolus is definitely reduced. Overwhelming statistics shows that these cases have less need of morphine, less catheterization, and fewer cathartics, and that the average temperature is lower. It is reasonable to believe that early ambulation decreases

the incidence of postoperative adhesions. Wound dehiscence shows no increase in the reports of these cases.

It is almost needless to remark that the early ambulatory patient has a much better morale than one confined to bed for a long time. When first seen, patients all think it wrong to get up in the first twenty-four hours, but as a rule they are quick to fall in line with the idea and are surprised that they can sit up and walk without too much pain. After the second day they are extremely proud and happy over their progress and have gained a self-confidence and mental state that aids a rapid convalescence.

From an economical standpoint there are many outstanding advantages to this treatment. The whole community benefits. The nurses are relieved of many duties, because the patient attends to his own wants and also to the needs of other patients. Second, early ambulation is a boon to the hospital, as the number of hospital bed days is cut almost in half. For instance, appendectomies average three to four days in the hospital instead of a week as formerly, and major cases seven days instead of fourteen. Third, this treatment is of advantage to the doctor who has an happier and healthier patient and the number of his calls is definitely reduced. Fourth, it is a boon to the economy of the community. The patients not only save money for themselves directly in reduced hospital bills, but they increase their yearly wage by getting back to work much earlier. At the same time they increase production in whatever line of work they may be engaged.

If the advantages of early ambulation are adequately explained to the patient and his confidence obtained, it is very seldom that cooperation is not enthusiastically given and none of my patients have ever stated that they have regretted their decision to try early ambulation. I do not believe it is right to exert an over amount of coercion. It is too much responsibility to take if anything serious should happen; especially, if early rising is not fully accepted in the community.

I think it is unnecessary to list contra-indications to early rising. It should be left to the physician's judgment to omit this type of treatment whenever the patient is too sick medically or surgically.

Early ambulation is physiological and economical. The primary principle of postoperative care is to maintain the normal physiology of the body and



have it interrupted for the shortest possible time. On the basis of review of published cases and personal experience for over ten years, it seems safe and logical to allow patients out of bed in the majority of cases within twenty-four hours after operations.

I am enthusiastic about this treatment and in the past twelve years of experience I have come to the point where I send 50 per cent of gall bladders home in five days, 90 per cent of appendectomies home in four days, and the majority of hernias home in seven days. I have yet to regret early ambulatory treat-

ment of patients, and know of no harm or complications which may be attributed to it.

In these days of shortages it behooves medical men to take advantage of every opportunity which presents itself to help alleviate that shortage. The economy in the decrease of hospital bed days, expense to patients, and nursing care and the decrease of doctor's visits are a real and definite benefit to the community where early ambulation of both medical and surgical patients is practiced. I recommend early ambulation as a sound advance in postoperative surgical treatment.

## EARLY POSTOPERATIVE RECOVERY IN SUPRAPUBIC PROSTATECTOMY

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ANY procedure, which offers to rid the prostatic of his troubles speedily and promises him to be free from bags and clamps thereafter, is good treatment. The present report is concerned with such treatment. The results have been accomplished by prostatectomy through the orthodox suprapubic approach and without any special manipulations intended to repair the bladder neck or posterior urethra and without primary closure of the bladder. Rapid union has been obtained and also early return of uncomplicated urination. The postoperative hospital stay is surprisingly brief and one of our recent patients, aged 84, was discharged on the eleventh day.

It is not the intention to make comparisons with perineal prostatectomy or transurethral resection, but to let the results speak for themselves. A broad concept of the prostatic as a sick human is advocated rather than a method of surgery. The surgical treatment is an incident in the cure. It is not more important than pre- and post-operative care. The use of the suprapubic route offers much less chance of postoperative incontinence from a destroyed or weakened external sphincter or a persistent fistula. Transurethral resection is performed on small prostates where a second resection is rarely a necessity.

There has been an interest of late in the prepara-

tion of patients for surgery in which maintenance of electrolyte balance and acid-base equilibrium play an important part. This is especially true of intestinal surgery. Urologists have always paid attention to these items, realizing an upset of these factors leads to interference with kidney elimination. An already damaged renal system will be further depressed postoperatively. The proper use of water and saline with glucose must be understood, however, and the stress is on the use of less saline routinely than has been the mode.

The use of whole blood has been of major value. It is used when necessary preoperatively to restore red blood cells and hemoglobin to a minimal limit of safety. A patient with lowered hemoglobin and red count will not tolerate further depletion.

The evaluation of the prostatic prior to surgery has not changed. He still must come up to certain standards of physical examination, blood chemistry and renal function. Having arrived at a point of reasonable safety, he is operated on. Advocates of transurethral resection are not as exacting on these points and they may be right as applied to that method.

One great advance in preliminary preparation has been the use of the Foley catheter. It has saved the patient another operation, i.e. preliminary cystostomy. The Nelaton catheter more often does not drain all cases efficiently. It is quite easily dislodged and adds to the further embarrassment of an already distended bladder. The patient on Foley catheter

drainage is out of bed and walking around with relative comfort, since it is not easily displaced. Sometimes we use a Tiemann catheter. This is quite helpful in middle lobe hypertrophy. The ordinary catheter, Foley or Nelaton, riding high over the crest of the middle lobe, and pointing towards the bladder dome does not drain the viscus well. Because of its curve the Tiemann can be made to drain the very bottom of the bladder.

If studies show the patient to be in for a long siege of preliminary drainage, vasectomy is done in the beginning. Otherwise, at the time of operation, the start is made with bilateral vasectomy and the bladder then opened. Anesthesia is usually Pentothal.

Though an incision, approximately  $2\frac{1}{2}$ -3 inches in length, the previously distended bladder is opened and the gland is enucleated. In watching the blood pressure over a long series of cases it always seems to drop as the hypertrophy is being forced through the bladder neck into the bladder. It is our impression that the reason the perineal operation is less shocking is that it is performed from below the internal sphincter. The latter which is richly supplied by the autonomic nervous system is thus spared to a greater degree. To obtain this same beneficial effect do not try to remove all the lobes at the same time, first remove one lateral lobe plus the middle lobe, when present. This creates a large enough opening to push the remaining lobe through without forcible distention of the bladder neck. With the minimizing of shock there is less bleeding. Hemostasis is further aided by tampons of gauze steeped in boiling hot water, and by compression with a Foley catheter. It is rare for the author to use a bag of more than 30 cc. capacity. The catheter is attached to the thigh with adhesive under moderate tension for exactly four hours. A longer continual pressure of the catheter against the external sphincter will lead to permanent incontinence. A Freyer tube will take care of the postoperative drainage of the bladder. At the end of forty-eight hours it is removed and drainage is allowed through the Foley catheter, the bag of which has been gradually deflated to the point of merely retaining the catheter. After this the wound should close rapidly. When it has been closed tightly for forty-eight hours, the catheter is removed and the patient will usually void.

Essentials to early recovery are the maintenance of (1) proper red blood cell and hemoglobin levels

and (2) electrolyte balance and acid-base equilibrium.

To keep blood level up a transfusion of 500 cc of whole blood is given at the operating table. This helps to prevent shock and is a cardiac tonic. However there is bound to be some loss. Zimmerman reported measurements by the colorimetric method of Nesbit both during and after suprapubic prostatectomy. The average blood loss sustained during surgery was 56 cc. with a minimum of 22 cc. and a maximum of 105 cc. Postoperatively it was considerably higher, averaging 159 cc. with a minimum of 27 cc. and a maximum of 451 cc.

Iron is essential to metabolism and particularly in wound healing. Damashek<sup>4</sup> says when hemoglobin and red blood count are below normal, healing is slowed up.

White states,<sup>5</sup> "In so far as the importance of iron and cellular metabolism is concerned, it is quite clear at the present time that iron participates in several enzyme systems which are necessary for the oxidative process which maintains the life of the cell. The chief enzyme systems involving iron are called Cytochrome C and Cytochrome C oxidase. There is no evidence that one can increase cellular activity above normal by increasing the concentration of these enzymes, but it is likely that iron could be a limiting factor in circumstances in which the concentration of these enzymes is below normal levels. Under these conditions, the administration of iron would supply at least one of the factors required to restore cell activity to normal."

Best and Taylor<sup>3</sup> in their late edition of "Physiological Basis of Medical Practice," say, "Besides its well known function as an essential element in the hemoglobin molecule, and as a constituent of other respiratory pigments, iron appears to play a role in the nutrition of epithelial surfaces. Abnormal hair growth, glossitis, fissures around the corners of the mouth and localized thickening of the mucous lining of the esophagus leading to dysphagia occur in anemias due to iron deficiency and are cured by iron administration."

Frequent blood checks have shown a drop in total red cell count and hemoglobin. In the early postoperative period it is usually in proportion to the amount of active bleeding. Patients with a lower red count and hemoglobin have lost their clotting power and tend to bleed still more. We resort to further transfusions to check this. Later, lessening



of red cells where there has been no further bleeding, may be due to absorption of toxic material from the wound or from depressed kidney function, or it may be an early sign that the gland removed was malignant. The latter has been the experience in some cases even where the pathological report has been negative. The fairly rapid depletion of blood elements for no apparent reason in the presence of negative laboratory and x-ray findings should at least put the observer on guard for cancer.

In the beginning blood counts were ordered only on those patients who seemed to have lost considerable blood and on those who were not healing rapidly. Later, as the importance of doing so was realized postoperative blood checking was made a routine.

It is the belief that postoperative care should push blood builders—protein foods, liver, iron, and, when necessary, repeated blood transfusions. The vitamins increase the appetite and are essential to the general well being of the patient. It is the impression they work indirectly on the healing wound.

The second essential to recovery is maintenance of electrolyte balance and acid-base equilibrium. Renal activity and freedom from dehydration must be assured. The proper administration of fluids plays a significant role here.

The water loss in sick surgical patients has been estimated and it is found that 1000 cc.—1500 cc. was the average daily amount required for water of vaporization. Water of vaporization is lost by way of the skin and lungs and is part of the heat control mechanism of the body. Under conditions such as fever, excessive sweating, hot humid weather and hyperthyroidism, this loss may be 2000 cc. or more each day. After the heat dissipating mechanism is supplied, the remainder of the available water is utilized for urine output. It has been shown that approximately 500 cc. of urine is the minimum daily amount required to excrete 35 Gm. of waste material, an average daily amount. To do this, normal kidneys must function at a maximum concentration power, shown by a high specific gravity of the urine. With the volume of urine less than 500 cc., retention of waste material will occur, manifested in the blood by an increased non protein nitrogen. If the kidneys are diseased and cannot concentrate normally, more water is needed. With inability to concentrate urine above a specific gravity of 1010,

about 1500 cc. of urine are needed to eliminate the 35 Gm. of waste material.

This means that large quantities of water must be ingested, since the prostatic will require them to insure adequate drainage and maintenance of kidney function and to prevent dehydration. In the first two or three postoperative days, the bulk of this fluid is administered by vein and the remainder by mouth. In so doing, one minimizes the possibility of collecting fluid in the stomach in large amounts. Very often there is a slowing up of peristalsis of the stomach and intestines. This in turn leads to nausea and vomiting. In this process the body is depleted of fluid and salts, adding to the possibility of upsetting water and salt metabolism with eventual breaking down of kidney elimination. The author aims to get at least 3500 cc. total fluids into a patient daily. The method is to give 1000 cc. 5 per cent glucose and saline and 5 per cent glucose in 1000 cc. of distilled water by vein, leaving 1500 cc. to be taken by mouth. Distention of bowels, hiccough and many of the other abdominal complications following prostatectomy are unusual in the author's experience. In sick surgical patients, excessive perspiration, vomiting or diarrhea, the amount is increased as loss of salt leads to depression, fatigue and loss of bodily vigor. The glucose solutions are valuable in the prevention of liver complications and acidosis as well as the supply of food to the body in the early critical stages where food cannot be taken.

An increase in healing potential in patients who have been transfused has been observed. For the purpose of comparing blood pictures discharged cases were checked where healing was slow or delayed. In spite of incompleteness of their blood record, these conclusions seem likely:

(A) When blood level remains relatively normal or shows only a slight loss, healing proceeds uninterruptedly. Bladder wounds close early from eighth day on and spontaneous voiding follows catheter removal. Early discharge, under two weeks, is the rule.

#### CASE SUMMARIES

Patient J. deF.		One stage Prostatectomy	
Pre-op blood count	4,600,000	Hgb.	95%
Third day post-op	4,780,000		94%
Fourth day post-op	3,700,000		79%
Tenth day post-op	4,600,000		98%
Catheter removed on tenth day. Voided spontaneously.			
Wound remained closed. Home on eleventh day.			

Patient V. C.	One stage Prostatectomy
Second day post-op	4,600,000 Hgb. 82%
Fourth day post-op	4,310,000 85%
Sixth day post-op	3,910,000 73%
Ninth day post-op	3,890,000 73%
Twelfth day post-op	3,900,000 75%

Twelfth day catheter removed, wound remained tight. Patient voided on discharge.

Patient L. B.	One stage Prostatectomy
Pre-op	4,840,000 Hgb. 85%
Second day post-op	4,680,000 75%
Sixth day post-op	4,430,000 87%

On the tenth day wound tight for two days. Catheter removed. Patient voided and discharged on thirteenth day.

Patient A. A.	One stage Prostatectomy
Pre-op	4,210,000 Hgb. 82%
First day post-op	4,410,000 80%
Third day post-op	3,890,000 76%
Seventh day post-op	4,160,000 82%
Ninth day post-op	4,300,000 84%

Twelfth day wound tight for thirty-six hours. Catheter removed—voided—home on fourteenth day.

Patient F. L.	One stage Prostatectomy
Pre-op	4,640,000 Hgb. 72%
Twelfth day post-op	4,240,000 79%

On tenth day wound tight. Catheter removed and patient voided. Remained dry thereafter.

Patient T. E.	One stage Prostatectomy
Fifth day post-op	3,700,000 Hgb. 72%
Seventh day post-op	4,010,000 80%

Tenth day wound dry. Catheter removed and patient voided.

Patient D. K.	One stage Prostatectomy
Pre-op	4,300,000 Hgb. 90%
Tenth day post-op	3,890,000 79%

Wound dry. Catheter removed—voided on tenth day.

Patient J. A.	One stage Prostatectomy
Pre-op	4,780,000 Hgb. 75%
Sixth day post-op	4,100,000 78%

Ninth day catheter removed. Patient voided. Wound remained dry. Home on eleventh day.

Patient M. P.	One stage Prostatectomy
Ninth day post-op	5,520,000 Hgb. 75%

Wound tight, catheter removed. Patient voided on eleventh day.

## (B) Cases showing low hemoglobin and low blood count in delay closure.

Patient I. C. Two stage Prostatectomy in patient with diabetes and tuberculosis. Numerous large and small stones removed at cystotomy (first stage).

Pre-op second stage	5,020,000 Hgb. 80%
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Wound closed on eighteenth day. Following hemorrhage the wound was reopened.

Twentieth day	2,810,000 Hgb. 55%
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Transfusion 500 cc. of whole citrated blood.

Twenty-first day	3,940,000
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Wound closed. Remained tight. Discharged on twenty-seventh day.

Patient W. T.

In pre-operative period several transfusions were given to raise low blood and hemoglobin level.

On admission	3,010,000 Hgb. 60%
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Two days pre-op	4,010,000 74%
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Four transfusions were given post-operatively of 250 cc each.

Fifth day post-op	2,010,000 Hgb. 52%
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Tenth day post-op	2,200,000 50%
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Sixteenth day post-operatively	4,010,000 84%
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Catheter removed on twentieth day. Voided freely. Wound remained dry.

## (C) Demonstrating the value of blood building stimulants in promoting early healing.

Patient W. W.

Two stage Prostatectomy

Massive bladder hemorrhage and urinary retention treated by cystotomy and repeated transfusions.

On admission	3,400,000 Hgb. 56%
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Pre-op second stage	3,380,000 58%
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With transfusions	4,300,000 74%
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Third day post-op	4,250,000 62%
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Thirteenth day post-op	4,100,000 73%
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Catheter removed on fourteenth day. Wound dry. Patient voiding.

Patient W. B.

Transfusions given pre-operatively.

Pre-op	3,810,000 Hgb. 64%
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	3,800,000 74%
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Third day post-op	3,680,000 75%
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Wound closed on seventh day—catheter removed on eighth day. Dry and voiding.

Patient P. R.

Arrested Tuberculosis

After using iron and liver therapy with transfusions, the count was brought up to the pre-operative count.

Pre-op	3,870,000 Hgb. 78%
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Second day post-op	3,210,000 63%
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Fifth day post-op	3,980,000 58%
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Transfusion 500 cc. of whole blood.

Seventh day post-op	3,290,000 72%
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Eleventh day post-op	3,550,000 73%
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Catheter was removed as wound was dry. Patient voided—home on eleventh day.

Fifteenth day post-op	4,210,000 (at home) Hgb. 79%
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Post-operative time required for bladder closure in last twenty-five cases (tight, no suprapubic leakage and voiding.)



NO. OF DAYS	NO. OF CASES
7	1
8	3
9	3
10	4
11	1
12	2
13	2
14	2
15	1
16	3
20	1
27	2

(Average 12.4 days)

Post-operative hospital stay.

NO. OF DAYS	NO. OF CASES
11	3
12	4
13	2
14	2
15	3
16	3
17	2
18	2
19	1
20	1
27	1
28	1
29	

Fourteen out of twenty-five patients were home in fifteen days or less after removal of the gland.

SUMMARY

Suprapubic prostatectomy is reputedly the most drawn out means of correcting urinary retention due to hypertrophy of the prostate gland.

The results reported with this method do not agree with this statement. Rather do they compare quite favorably with transurethral resection.

In addition to any refinements in technique, it is the belief that this has been accomplished by maintaining a high hemoglobin and blood level during the healing period. Recent reports on the role of Cytochrome C and Cytochrome C oxidase are interesting when viewed in this light.

While post-operative hospital stay has averaged seventeen days, fourteen out of twenty-five cases reported were in the hospital fifteen days or less.

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MICROCEPHALY IN THREE SUCCESSIVE PREGNANCIES

LOUIS NEWTON, M.D., and T. SMITH MCLEAN, JR., M.D., *Bridgeport*

Mrs. H. K. gave spontaneous birth to microcephalic babies on November 22, 1938, March 29, 1945, and July 25, 1946. The maternal history is entirely non contributory. The paternal grandfather committed suicide at the age of 54. The only brother on the father's side has a microcephalic child.

This unusual occurrence prompted us to investigate the records of the obstetrical department and accordingly we found that from January 1938 to January 1946 in a total of 15,421 deliveries there were 129 cases of congenital malformation as follows:

Hydrocephalic .....	30
Hydrocephalic with spina bifida.....	6
Hydrocephalic with absence of fingers and toes	1
Anancephalic .....	29
Anencephalic with spina bifida and clubbed foot .....	3
Spina bifida .....	24
Spina bifida with imperforate anus.....	1
Clubbed foot .....	7
Clubbed feet .....	4
Harelip (unilateral) .....	3
Harelip (bilateral) .....	2
Harelip (unilateral) with cleft palate.....	8
Harelip (bilateral) with cleft palate.....	1
Mongolian idiot .....	2
Meningocele .....	2

From the Obstetrical Department of Bridgeport Hospital

Imperforate anus .....	3
Congenital dislocation of hip.....	1
Bilateral cataract .....	1
Malformation of face and lips.....	1

These anomalies were discovered immediately upon the birth of the babies. We have no figures of the number and types of anomalies discovered in the nursery or in later life, such as gastro-intestinal obstructions, duplications of or absence of genital organs, congenital heart pathology, etc., nor are we including minor anomalies.

A great many theories have been advanced to explain the occurrence of congenital malformations. The underlying cause or causes are still obscure; nevertheless, it is generally agreed that heredity plays a great part, although there are those who claim that environmental influences are the most important factors in their causation.

In favor of environmental factors are the following theories:

1. Poor nutrition causes vascular changes in the endometrium, which in turn influences the developing ovum.
2. Some claim that human protoplasm is more unstable in the spring than in the summer, and the spring variations in barometric pressure may have an influence on the growing ovum.
3. Malformations can be produced experimentally in fish by altering the temperature, the chemical constitution of the environment, and the oxygen available.
4. There is a high incidence of abnormalities among aborted human embryos and ones from tubal gestations.
5. Radium and roentgen exposure will arrest the growth of the human embryo.
6. The occasional occurrence of cataract in babies whose mothers had German measles and other exanthemata in the first few months of pregnancy.

In favor of the heredity theories are:

1. Frequent duplication of defects in brothers and sisters.
2. In many siblings the malformations are the same, or they represent the same processes (spina bifida in one region or the other).
3. Among twins anomalies are more frequent in monovular twins, as it is well known that total heredity is the same in twins arising from one egg.

Investigations also show that congenital anomalies often occur in later than in earlier born siblings; also more often in old mothers than in young mothers; and miscarriages, stillbirths, and premature births occurred most often in the pregnancy immediately preceding the birth of the defective child.

With this in mind we have investigated our own case histories of the three largest groups of anomalies.

The hydrocephalic group did not reveal any information of statistical significance with the exception of one case that had seven miscarriages preceding the birth of a hydrocephalic baby. In this group there was one set of binovular twins in which twin A was hydrocephalic and twin B was normal.

In the anencephalic group the histories again did not reveal any information as to the possible etiology with the following exceptions: In one case the patient's sister had an anencephalic monster and in another case of binovular twins, twin A was normal and twin B was anencephalic.

In the spina bifida group there were only two cases in which these births were preceded by one miscarriage in each case. In this same group there was one patient whose first child had anencephaly with spina bifida and the second child was apparently normal; she is now included in this group because the third pregnancy resulted in a spina bifida. In another case in this group the previous pregnancy resulted in a hydrocephalic baby. One case of binovular twins resulted in twin A with spina bifida and twin B was normal.

Among the other congenital defects listed the two mongolian idiots were born to the same mother. This case is interesting because investigation of the husband's semen revealed a low count, poor motility and 60 per cent defective sperm morphology. Of the fourteen harelip cases at least three were reduplications.

As nearly three-fourths of the above listed anomalies occurred in primiparous patients, knowledge of the termination of subsequent pregnancies would be of great value for this report; however, we were unable to conduct such an investigation.

#### SUMMARY

A case is presented in which three successive pregnancies resulted in microcephalic babies; there is another microcephalic baby on the paternal side.

The current theories as to the causation of congenital anomalies are briefly enumerated. The con-



genital malformations among 15,421 deliveries are listed.

Here we are faced with a problem in human wastage; and, admittedly, we are far from its solution. Obviously many cases cannot be helped at all. Some can be salvaged by plastic and reconstructive surgery. At present it might be wise for the parents of malformed children to limit reproduction.

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## MINUTE NODULES AND CYSTS OF A FALLOPIAN TUBE: CASE REPORT

MAURICE R. MOORE, M.D., *Norwich, Connecticut*

I DESIRE to report a case of "minute nodules and cysts of a Fallopian tube" which was found at operation in a midaged woman and appears to be explained by the cell rest theory of Cohnheim. He pointed out that in the course of development groups of cells might be separated or dislocated from their normal relationship and exist in a dormant condition as "rests." Such displaced cells do not carry out their normal functional activity; and he believed that from them, tumors often take origin.

#### HISTORY

A white female, aged 47, was admitted to the hospital complaining of a "deep ache" throughout the pelvis. The family history was not contributory. Past history revealed that menstruations had always been irregular in quantity, duration and intermenstrual periods; also that throbbing headaches occurred occasionally. The "deep ache" in the pelvis began six months before admission and had gradually increased in severity; working made it worse and it was routinely more noticeable at night but never to the degree sufficient to prevent sleep.

#### EXAMINATION

On physical examination the patient was well nourished and well developed. Head, thorax, upper abdomen and extremities were negative. A large round mass was found attached to the posterior part of the uterus and this was painful on movement. Urine and blood findings were normal.

Two days after admission to the hospital, a supravaginal hysterectomy and right salpingectomy were done. The remaining pelvic organs were considered normal.

#### PATHOLOGICAL REPORT

Uterus measures 10 x 8 to 3 cm.; an intramural mass 4.5 cm. in diameter typical of fibromyoma was found present

in the upper third of the posterior wall of the uterus; the muscle wall was firm and the endometrium greyish in color. The fallopian tube measures 5 x 1-1.2 cm. The posterior surface is almost completely covered by small yellowish-gray nodules; these formations end at a sharp margin in correspondence with the superior surface. The anterior surface shows two similar nodules. The muscle wall and mucosa are thickened and slightly firm.

*Microscopic examination* shows the nodules and cysts to be situated in the subserosa. A layer of elongated cubical and oval cells with dark staining nuclei and clear cytoplasm line the cysts; 2 to 14 cells deep. The internal surface is smooth. A hyaline staining, globular material is found partly filling the cyst spaces. The nodules are invariably smaller than the cysts and consist throughout of the same type of cell as is found to line the cysts. Peripheral to the formations, also throughout the muscle wall and mucosa there are a few neutrophilic polymorphonuclear leukocytes, histiocytes and a moderate amount of granulation tissue.

#### DISCUSSION

Beginning about 1900 considerable writing on "minute nodules and cysts of the Fallopian tube" appeared in the literature. The authors give morphological descriptions which are almost identical and very characteristic. The interpretations of their findings, however, differ considerably. Suprarenal tissue, germinative epithelium, inflammatory processes, etc., have been suggested as the origin.

It is not possible to form an opinion about the characters of these formations merely on the basis of morphological characteristics. The number of nodules and cysts present in the single cases is variable. There are tubes with only one or two cysts

*From the William W. Backus Hospital*

and others when the formations appear in such numbers that they stand close together.

Among two hundred and sixty-six cases reported in literature, one hundred and fifty-eight cases (50.4 per cent) were free from macroscopic in-

fluence on the posterior aspect. In some cases where the cysts were numerous the posterior surface appeared completely free. This behaviour is rather impressive and of special interest in that the posterior part of the tube has a close relation to the Wolffian body which would offer a series of cell rests.

Schickele<sup>3</sup> maintains that the nodules and cysts are found only in sexually mature woman, but it seems as far as literature is concerned this question is still open for research. It is definitely known that many cysts and nodules are to be seen only with the aid of the microscope and this factor allows a certain number of cases to pass unrecognized, both at the operating table and at autopsy.

#### SUMMARY

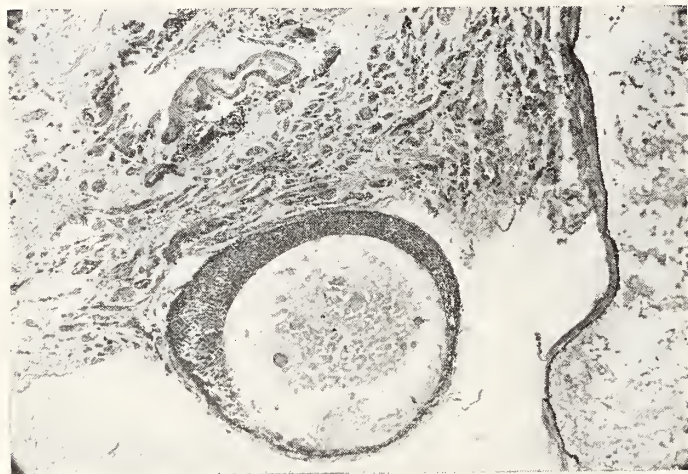
1. Minute nodules and cysts are found in the subserosa of Fallopian tubes, both unilateral and bilateral.

2. Hormonal and inflammatory influences cannot be observed.

3. The localization of the cysts is a typical one and almost exclusively limited to the posterior surface of the tube, up to the upper side. This indicates that no matter what the exciting cause is we are dealing with an embryological factor "a particularity of the cells, which can find its explanation hardly anywhere else but in their embryology." (R. Meyer.)

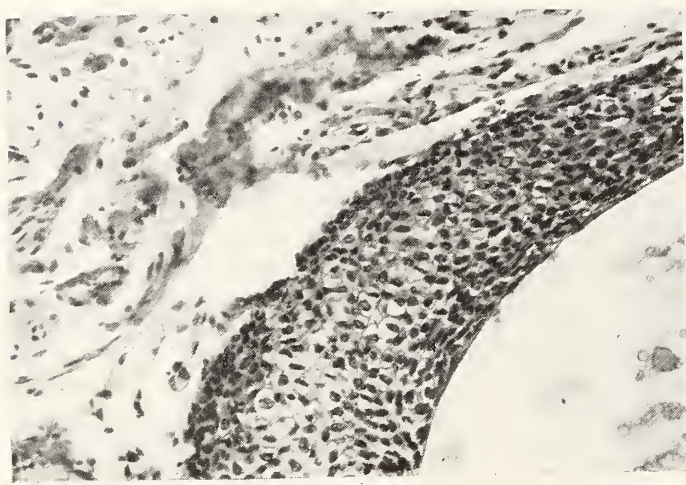
4. This condition is routinely an incidental finding and pathologically it is of interest in that it must be recognized and understood.

5. The case here reported is unilateral; the condition is almost entirely confined to the posterior surface of the tube; the clinical manifestations may or may not have been influenced by these formations as sufficient other pathology was present to explain her symptoms



No. 1

A cyst in the subserosa: stained with hematoxylin and eosin.  $\times 100$



No. 2

A portion of the wall of a cyst: Stained with hematoxylin and eosin.  $\times 400$

flammatory change. In one hundred and eight cases, inflammatory changes were found, consisting of more or less small adhesions.

Obvious difference between the right and left side could not be observed; not infrequently they occur bilaterally.

Rossa<sup>1</sup> and Schickele<sup>3</sup> showed that the formations are localized mainly at the posterior surface of the Fallopian tubes, while R. Meyer<sup>2</sup> describes positive findings on the anterior surface, admitting preva-

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## THE LIBEL SUITS OF THE AMERICAN MEDICAL ASSOCIATION

MORRIS FISHBEIN, M.D., *Chicago*

(Continued)

Night after night Brinkley mingled with the music from his station announcements concerning the value of goat-gland transplants. His programs were keyed to a listening audience of elderly men likely to be awake attending to various physiological functions between two and four A. M. He had developed the four-phase compound operation, claimed to be "the best thing known for impotency, high blood pressure, large prostate, sterility, neurasthenia, dementia praecox or any disease that is not malignant of the prostate." Patients who came to the hospital on Monday usually left by Friday; next week's patients were not to know how this week's patients were going. The hospital had about fifty beds; the average fee was \$750. The glands of a very young species of capricornus might cost \$1,500. The surgery was crude. A carpenter from New Jersey who had received one of these operations died in St. Louis of tetanus. The Milford technicians had fastened an old rubber heel over his wound to keep the issues from extruding the goat glands as a foreign substance.

As Brinkley said, people wrote to him in great numbers. He claimed in an interview in 1930 that he was receiving three thousand letters each day. In 1933 he discontinued the goat gland operation.

One of his early cases was Charley Tasine. Let the old doctor tell it:

"The boys in the barber shop were kidding Charley whether he would have an operation or not, and he said he would if he had the money, and I was coming along and I said, 'You don't have to have any money; come up to the hospital and I will give it to you for nothing.' I took him up and the operation was entirely successful. He was a bachelor and he got married right afterwards. He claimed he had become a regular billy goat, twice as good as any other man around Milford. He was one of those boasting fellows, liked to blow off as to his ability."

The son born to the Tasines was duly named Billy in recognition of his origin.

About 1926 Brinkley organized the Brinkley Pharmaceutical Association. Druggists who joined sold preparations recommended by broadcasts of the Brinkley Medical Question Box. The broadcaster would read the letters received from the sick. He would tell them to get "Women's Tonic No. 50, 67, and 71" or "Men's Prescription No. 60, 87 and also No. 64." The prescriptions were common preparations of ordinary drugs sold under these numbers. The druggist would keep a large portion of the money and send the remainder to Brinkley for advertising the preparation. Thus the doctor prescribed for a patient whom he had never seen, basing his diagnosis on written descriptions of the symptoms. In Dr. Brinkley's broadcast for April 1, 1930, presumably representative of all, he prescribed for forty-four different patients and in all, save ten, he advised the procurement of from one to four of his own prescriptions. Here are two which are typical:

"Here's one from Tillie. She says she had an operation, had some trouble ten years ago. I think the operation was unnecessary, and it isn't very good sense to have an ovary removed with the expectation of motherhood resulting therefrom. My advice to you is to use Women's Tonic No. 50, 67 and 61. This combination will do for you what you desire if any combination will, after three months' persistent use.

"Sunflower State, from Dresden, Kansas. Probably he has gallstones. No, I don't mean that; I mean kidney stones. My advice to you is to put him on Prescription No. 80 and 50 for men, also 64. I think that he will be a whole lot better. Also drink a lot of water."

The preparations prescribed were secret, and the prescriber shared in the profit from the sale. This, from either an ethical or scientific point of view, stinks to high heaven.

The *Kansas City Star* and *The Journal of the American Medical Association* began to tell the truth about the Brinkley broadcasting. Eventually

the Federal Radio Commission was moved to action. Brinkley was cited to prove that his programs were in the public interest, convenience and necessity. Off he went to Washington with a trainload of satisfied patients in an attempt to prove to the commission his honesty and scientific ability. He had built his station in 1923; in June 1930 the Federal Radio Commission refused to renew his license. So he sold the station in 1931. He sued the *Star* and *The Journal* and their editors for millions and millions of dollars, but these suits never came to trial. He appealed to the Court of Appeals in the District of Columbia, but they sustained the Radio Commission. Then the Kansas Board of Medical Examiners revoked his license to practice. He appealed to the Supreme Court of Kansas. The judges of the Supreme Court spoke with fine diction in announcing their decision. They held that Brinkley was "an empiric without moral sense, and having acted according to the ethical standards of an imposter, the licensee has performed an organized charlatan-ism until he is capable of preying on human weakness, ignorance and credulity, to an extent quite beyond the invention of the humble mountebank." They spoke of him as one "who was fleecing the defective, the ailing, the gullible and chronic medicine takers who are moved by suggestion, and is scandalizing the medical profession and exposing it to contempt and ridicule."

And now came his candidacy for governor in the state of Kansas. He had lost his radio station, but he toured the state in a truck equipped with a loud speaker, probably the first political candidate to use this technique. He purchased time on other stations. He promised free motor licenses, free textbooks, better roads. Kansas he pointed out, is a dry state. "If I am elected," he said, I will build a lake in every county in Kansas. Then the water will be evaporated from these lakes and will pour down as gentle rain on the fertile fields of Kansas." He filed late in his candidacy so that it was necessary to insert his name in writing on the ballots. The election clerks were directed to discard all ballots on which his name was not perfectly spelled, even to dotting the "i." Nevertheless, he polled 183,000 votes, which was some 14,000 less than were polled for the winning candidate. The local politicians have told me that he would have been elected easily if all the ballots had been counted. No doubt they are right, because it is said he received more than 20,000 votes in Oklahoma, and he was not even running in Oklahoma.

At a subsequent election he polled 244,000 votes and was almost elected. He then tried to file a third time, but now the people of Kansas had lost interest.

In 1933 Brinkley closed up in Kansas and moved to Del Rio in Texas. I first saw Del Rio myself in 1939. In the hot sunshine lackadaisical Mexicans sleep along the curbstones. The village, for it is that is typical of all of the towns along the Rio Grande. Along the roadside are signs reading, "This is God's country—don't drive like hell through it." The warning is no doubt necessary, for there is little in Del Rio to hold the casual tourist. In Del Rio Brinkley registered at the hotel and soon began using some of its rooms for his patients. By now he had abandoned the four-phase compound operation which involved the transplantation of the glands of the goat and had undertaken a new procedure based on some of the researches of Steinach, famous Austrian rejuvenator. In this operation Brinkley simply cut the tube leading from the male sex glands and put inside a drop of mercurochrome. A little later the operation was again modified so that the tube was tied with a suture. This he called the Steinach No. 2 operation. Most experts are convinced that the success of the operation in a few cases is due to the power of suggestion.

Shortly after arriving in Del Rio, Brinkley apparently came to terms with the Mexican government and obtained a license for a radio station known as XERA in Villa Acuna, Coahuila, Mexico. This was at its best the most powerful radio station in the North American continent. The Mexicans, who are not wholly a stupid people, built tall steel tower south of his station so that the broadcasts had very little circulation in Mexico. They did, however, have a tremendous reach up into Minnesota, a fact which was particularly annoying to the Mayo brothers. From this station were broadcast not only Brinkley's lectures, read in a strange but compelling monotone, but also all sorts of announcements by patent medicine and similar commercial interests. Special attention was given to garlic tablets for high blood pressure.

The stay of Brinkley in Del Rio was profitable—so profitable indeed that his payroll at the time I visited Del Rio in 1939 had reached \$20,000 weekly. During the years from 1933 to 1938 the Brinkley Hospital in Del Rio had taken care of some 15,000 patients, of whom the majority paid \$750. This sum the doctor guaranteed by an excellent commercial organization which would accept a mortgage on a farm, an attach-



ment to a bank account, the family jewels or anything that could be made to look like \$750. Bear in mind also that \$750 was only a minimum. Once the patient was in the hospital a number of interesting devices were developed for promoting what are technically called "extras."

When I saw Brinkley, I observed a little man with a little gray goatee, wearing a gray suit, but the goatee and the suit were the only appurtenances that were not brilliant. On one hand he wore a diamond ring which was said to be fourteen carats, and on the other hand another diamond ring said to be eleven carats. In his tie was a stick pin of a considerable number of carats, and underneath the stick pin was apparently a solid gold tie clasp set with diamonds, the entire device being about two inches long and one-quarter inch wide. From his watch chain there dropped a Masonic emblem with several diamonds also large in carats. Mrs. Brinkley, usually known as Minnie, who in 1921 had also acquired a diploma from the Kansas City college, was likewise somewhat profusely decorated with diamonds. (Remember that diamonds are negotiable everywhere and easily transported when one needs must travel hastily.) In fact, the combination resembled in their brilliance the twin chandeliers of a house of ill fame. The illumination was not limited, however, wholly to the jewelry. Brinkley traveled to and from the court house in a great red sixteen-cylinder Cadillac, on which his name appeared thirteen times—twice on each hub cap, on the front and back, on the trunk and on the sides.

Brinkley would sit quietly in the court room, usually chewing a toothpick and combing his beard with his fingers. In his vest pocket he carried also a combination gold tooth and ear pick, with which he used to explore his teeth, his nose, his ears, and then view the results with a tender, solicitous expression. Usually beside him sat the glamorous Rose Dawn. Mrs. Brinkley did not come in often; when she did, she merely peeked through the door. There sat too beside him on occasion some of the virtuosos of station XERA, including the "Mexican Nightingale" and a sleek Mexican announcer.

Yes, the gland business did well for Brinkley in Texas! He owned three yachts, named John R. Brinkley I, II and III, one of them bought from Joe Schenck of the movies, first used by Douglas Fairbanks. It was a 170-foot job and carried a crew of twenty-one. Brinkley was created an admiral by the governor of Kansas; a picture of Brinkley in his

private admiral's uniform hung in the office of the editor of the Del Rio newspaper. Incidentally, Brinkley rented his large yacht to Edward VIII and Wallis Simpson for their honeymoon in the Mediterranean. Brinkley's home and the six acres of ground around it were valued at \$200,000. There was a great rose garden artificially irrigated, a swimming pool with colored tile, large greenhouses with orchids, live penguins and tortoises from the Galapagos. On the lawn were great statues of Romulus and Remus with the she-wolf that bred them, purchased by the doctor in Italy after he adopted the name Romulus as a middle name. There was a great marble group of the Three Graces bought in Italy and designed to adorn Mrs. Brinkley's grave at some future date. Two great fountains sparkled in the sun, and at night over each of them an electric sign spelled out the word "Dr. Brinkley." Indeed the repetition of his name on every possible spot in the doctor's vicinity assumed proportions almost pathological. His name was found three times on the swimming pool, once on the pipe organ, twice on the radio station, twice in six inch letters on the house gates, embroidered on the uniform jumpers of the crews of the yachts and painted on all of the yachts in innumerable places. On the great wooden table in his dining room his name was carved where each guest sat; and whose name do you think was on the napkins? J. C. Furnas, who spent some days in Del Rio, is authority for the fact that the name was not carved on the backs of the tortoises.

Brinkley never did quite remember how many motor cars he had, but he estimated that it might be somewhere around thirteen or fourteen.

Eventually the Texas State Board of Medical Examiners began to be annoying, whereupon Brinkley moved his medical establishment to Little Rock, Arkansas. He continued to maintain his home in Del Rio and the radio station in Villa Acuna. Arkansas had long been known for the laxity with which it granted medical licenses. The eclectic board continued to make easy the lives of its licensees. In Little Rock Brinkley bought a country club which he rededicated and called "the most beautiful hospital in the world." It had been built by the Shriners of Little Rock and included a mammoth stone structure fronting on a 100-acre lake, surrounded by 360 acres of golf course. In the town of Little Rock he set up a clinic in an old chain store building which was modernized with glass brick and chrome trim. Here a staff of thirty-five persons handled

2,000 letters daily which came in response to the Brinkley broadcasts. So great had the business become that it was necessary for Brinkley to secure a staff of assistants, mostly renegade doctors, some of them previously addicted to drugs or alcohol, some of them osteopaths. Closely allied to the clinic was the Romulus Drug Store, with pills for relieving acid stomach at five dollars a hundred and a laxative at three dollars for six ounces.

About this time Brinkley took over a technique that had been developed by a Birmingham doctor named Burr Ferguson. This technique involved the injection of an ampule of what was said to be 1:1000 hydrochloric acid. The patient got five ampules for one hundred dollars, actually worth about twenty-five cents each. The patient was advised to take the ampules to his family doctor on leaving the Brinkley sanatorium, and the family doctor was usually paid well for giving the injections. Unfortunately, the ampules were of a poor quality of glass; when the contents were examined by the chemical laboratory of the American Medical Association, it was discovered that most of the acid had been taken up by the glass of the ampule. What the patient got was essentially a solution slightly blue in appearance, about what he would get if you threw a bottle of bluing into Lake Erie.

Brinkley was accustomed to commute from Little Rock to Del Rio in his own Lockheed monoplane with a pilot and copilot. This was a twelve-passenger ship, for which he paid \$58,000 and then added more than \$20,000 worth of extras.

In the 1920's Brinkley sued the Kansas City *Star* and the American Medical Association for some millions of dollars, but eventually dropped that suit. In 1938 a description of Brinkley and his work was published in *Hygeia* under the title "Modern Medical Charlatans." He then sued the American Medical Association and myself as editor for \$250,000, claiming libel. In the testimony given in that suit there came forth many of the facts that have here been told. The suit went to the jury following a remarkable charge by Judge R. J. McMillan which was one of the strongest indictments of charlatanism ever to come from a court. The judge said, at one point, "The words quack and charlatan have substantially the same meaning. Many definitions can be found in the dictionaries or in the reports of the courts. A common definition of the word quack is to make vain and loud pretension, especially of medical ability; to boast, to vaunt aloud or be a boastful

pretender to medical skill or to make extravagant claims for a cure-all; to advertise with fraudulent boasts." Of ethics, the judge said, "Most people know in a general way what you mean by ethics but few of us think or speak in terms of definitions . . . It has practically always been considered unethical for physicians to advertise, that is to say to advertise further than to call the attention of the public to the fact that they were ready to practice . . . Advertisements by which prizes are offered to secure patronage or by which claims are made of superior skill or ability are not ethical." And again "The conduct of the plaintiff Brinkley should not be measured against his own personal ideas with regard to what is proper. It should be measured against the ethics and approved conduct of physicians generally, and to such extent that his conduct as a physician varies from the rules of ethics recognized and observed generally he becomes subject to criticism . . ."

After a short stay in the jury room, the jury found the editor of *Hygeia* to be not guilty of the charge of libel.

On the witness stand in the libel suit Brinkley had testified that his income in 1937 had been more than \$1,300,000 and that it had dropped to something like \$800,000 in 1938. In an article printed in the *Saturday Evening Post* in April, 1940, J. C. Furnas ventured to predict, "In spite of treaties, medical associations, governments, cold-shouldering civic bodies, hell and high water, is is probably still a bad bet to sell Doctor (Brinkley) short." Brinkley had always been interested in politics. He had done enough for former Vice-President Curtis to cause that worthy to go in person to our State Department and to cause them in turn to prevent the Mexicans from interfering with Brinkley's station. His broadcasts during the closing days of station XERA had begun to be devoted to international affairs. He had urged the election of John Garner and had contributed often to the campaign funds of the national Democratic party. Observe that he aided both Democrats and Republicans. Indeed we find Dr. and Mrs. Brinkley listed among guests at a reception at the White House in 1940. In his politics Brinkley was a hard-shelled isolationist and a chronic Anglophobe. He was opposed to the entrance of the United States into the war. Somewhat later it appeared that he was also a contributor to the funds used by William Dudley Pelley, the anti-Semitic Silver Shirt leader who testified before the Dies



Committee that Brinkley had given him \$500,000. Yet with all the support that such contributions might have developed, the career of Brinkley, following the libel suit, pursued a course steadily downward. On March 25, 1941, he was confronted in a federal court with claims amounting to more than \$1,600,000, and he filed a statement in bankruptcy listing personal property that totaled \$46,845.16, 6 head of horses, 90 head of cattle, 1 sow, 6 geese, 2 guineas, 40 ducks, 50 chickens and 20 turkeys, all of which were resident not in Del Rio but in East La Porte, North Carolina. He had sold his last yacht for \$110,000 to the United States Navy and his private airplane to the British Purchasing Commission in order to get enough cash to pay some income taxes. The federal government felt that he still owed them more than \$113,000 in income taxes. In 1940 he had sold the hospital in Little Rock. His attorneys asserted that the malpractice suits had ruined him, and other judgments against him on such suits were well over \$1,000,000. With the loss of his funds came a physical breakdown. He departed for Kansas City and in 1941 opened a school for the teaching of airplane mechanics, which promptly also went into bankruptcy. Then his heart began to disturb him, and a piece of the tissue of the heart breaking away blocked a blood vessel in his leg, that requiring amputation. A few months more and in May 1942 he died.

The conditions that produced John R. Brinkley are not likely to be duplicated again. The licensing boards of the individual states are now, for the most part, above any possibility of such manipulation as was performed when Brinkley was licensed in half a dozen states by the so-called Eclectic Boards. The radio is now controlled by the Federal Communications Commission, and the advertising claims of nostrums and panaceas are subject to the supervision of the Food, Drug and Cosmetic Act of 1937 and the researches of the Federal Trade Commission operating under the Wheeler-Lea bill of the same year. The Post Office Department, through fraud orders, carefully checks on the use of the mails to defraud.

Observe that great charlatans of the Brinkley type are not halted by any increase in public knowledge or by any lessening of human credulity; it requires the social controls exercised by laws with powerful punitive qualities to check a superlative quack.

BEFSAL

On February 21, 1925, *The Journal* published an article about a drug called "Befsal," which was ex-

ploited by one Dr. S. Lewis Summers of Fort Washington, Pa., and by an agency called Synthetic Organic Products Co., New York City. The product, which was analyzed by the laboratories of the American Medical Association, turned out to be a substance of varying and unreliable composition containing salicylic acid and quinine. It was launched as a special cure for rheumatism. Suit was brought against the American Medical Association and Dr. Morris Fishbein for several millions of dollars for libel but the suit was dismissed when Summers died before it could come to trial. He had also filed another suit against Drs. George H. Simmons, Morris Fishbein, W. A. Puckner, Torald Sollmann and others. This suit also failed to come to trial.

#### NORMAN BAKER VS. THE AMERICAN MEDICAL ASSOCIATION

Norman Baker of Muscatine, Iowa, who headed a number of mercantile enterprises, including the ownership of a radio broadcasting station and an alleged cancer cure, was dealt with, editorially, in *The Journal* of April 12 and April 19, 1930, and in *Hygeia* for May, 1930. As a result of these publications, Baker brought suit for libel against the American Medical Association, asking one half million dollars in damages. This case came to trial in the federal district court in Davenport, Iowa; the trial opened on February 9 and continued until March 3, covering a period of nearly four weeks. Voluminous testimony was offered by the American Medical Association, both through physicians who went on the stand as experts and by scores of depositions that had been gathered by the Association from various parts of the Middle West; much testimony was also put in by Baker. On March 3, the jury returned a verdict for the American Medical Association.

The case was heard before Federal Judge Gunnar H. Nordbye of Minnesota. In this connection, Norman Baker's weekly paper, the *Midwest Free Press*, prior to the trial expressed the editorial opinion that because the case was going to be heard before a judge who was coming from Minnesota, Baker would "not get all that's coming to him." To quote:

"We fear he [Norman Baker] will not get all that's coming to him—Judge Dewey was to hear the case and at the eleventh hour now announces a judge from Minnesota coming to try the case—that may be O. K. but WHY WE ASK, is it necessary to go away out of our district to secure a Federal Judge—we wonder how Dr. Mayo, who is a power in Minnesota would like it if he were in Mr. Baker's

place and an Iowa judge from Muscatine section would hear the case—YES WE WONDER—Mr. Baker's formulas have accomplished more than Dr. Mayo ever did for cancer, and Baker will have to fight many years yet to educate the ignorant prejudiced and lazy thinking ones who are dominated by organized medicine." [Capitals as in the original.—Ed.]

The implications in this statement are fairly obvious.

The jury before whom the case was heard was a group of substantial farmers or retired farmers and merchants. Counsel for the Association were Messrs. Edward M. Burke and Clement L. Harrell of the law firm of Loesch, Schofield, Loesch and Burke of Chicago, with Mr. C. M. Dutcher of the firm of Dutcher, Walker and Ries of Iowa City, who are the attorneys for the Iowa State Medical Society. Norman Baker was represented by two attorneys, Messrs. Charles P. Hanley of Muscatine and J. C. France of Tipton.

Appearing as medical experts for the Association were Dr. Francis Carter Wood of New York, Dr. Joseph Colt Bloodgood of Baltimore, Dr. Burton T. Simpson of Buffalo, Dr. Max Cutler of Chicago, and Dr. Albert C. Broders of Rochester, Minn. Several other physicians also aided the Association, appearing either as witnesses during the trial or by depositions.

#### BAKER'S ENTERPRISES

Originally, Baker's enterprises seemed to have been wholly or mainly in the commercial field. He sold radio sets, storage batteries, flour, coffee, canned fruit, silverware, brooms, alarm clocks, overcoats, mattresses, automobile tires, typewriters, paints, and many other things. He advertised his wares not only through printed catalogs and through his magazine, *T N T (The Naked Truth)*, but, more important, over his radio station, KTNT of Muscatine. Baker's first excursion into the medical field seems to have been the use of his radio station to advertise an injection treatment for varicose veins, exploited by a Davenport physician.

Baker had two (and, for a short time, three) alleged treatments for cancer that were being given at Muscatine in the building that was known as the "Baker Hospital." They were (1) a treatment for "external" cancer, an arsenic powder exploited by Harry M. Hoxsey, whose methods<sup>1</sup> are also dealt with in these pages, and (2) the injection treatment

for "internal" cancers of one Charles O. Ozias of Kansas City—who also has received some publicity through *The Journal*.<sup>2</sup> When the American Medical Association, through its Bureau of Investigation first began warning the profession and the public against the Baker cancer-cure business, Baker made the fantastic claim that the American Medical Association had offered him a million dollars for his "cancer cure," in order that it might be withdrawn from the market, so that sufferers of cancer would be compelled to resort to surgery, x-rays, and radium. When Baker himself was on the stand during the first day of the trial, he denied that he had ever made such a statement, but his denial was offset by the presentation of a letter from the files of the Bureau of Investigation, signed "N. Baker" and which Baker had to admit he had dictated. In this letter Baker definitely stated that it was a "fact that the Medical Trust offered one million dollars on January 3, 1930 to suppress this treatment."

Norman Baker was the first witness to be put on the stand by the plaintiff, in order to show that the material published by the American Medical Association had caused him serious financial damage. Baker declared that his monthly receipts from his cancer-cure activities started at \$1,380 for October, 1929, climbed to \$75,232 for June, 1930, and, following the articles published by the American Medical Association, dwindled until in January, 1932, he took in only \$7,008.

#### BIOGRAPHICAL NOTES ON BAKER

Baker, on cross-examination, admitted that his education went no further than a year and a half of high school work. After leaving school he traveled around the country working in machine shops as a die and tool maker. After two years of this, he went into the vaudeville business, putting on "hypnotism" acts "along psychological lines—mental work." He continued in that field for about eight or ten years, but in 1914 came back to Muscatine, where he started to manufacture calliopes. This work was interrupted for a short time when he went on the road again "putting on an act." In 1920, his factory burned and he then started a mail-order business.

1. The Hoxide Cancer "Cure," J. A. M. A. 86:55 (Jan. 2) 1926. The Hoxide Quackery Again, *ibid.* 93:400 (Aug. 3) 1929.

2. The Ozias Hospital Association, J. A. M. A. 79:1869 (Nov. 25) 1922.



His broadcasting station went on the air in November, 1925, at which time he was running the "Tangley Institute," "Tangley Company," "Tangley Correspondence School," and some other things. He had a mail-order "art school," although he admitted that he could not paint a picture for his life. Nevertheless, he advertised to teach "oil painting in ten lessons by mail." Under the name of "Tangley Institute," Baker was broadcasting "to let the world know that varicose veins could be cured without operation." The Tangley Institute went out of existence when the "Baker Hospital" was opened.

From the evidence in the case, it appears that Baker's original intention was to make some financial arrangement with Ozias of Kansas City, whereby the Ozias "injection cure" for "internal" cancer could be used at Muscatine. Such plans, however, never materialized and Ozias testified that he had never sold, loaned or permitted Baker to use the formula. Baker was asked, when on the witness stand, who it was that told him what was in the Ozias mixture; he replied: "I refuse to tell." It was a fact, however, that two persons previously connected with Ozias in the exploitation of the Ozias "cure" were hired by Baker. One of these was a woman, Mary Turner, and the other a chiropractor, Charles Gearing. The Turner woman admitted that he had given thousands of injections of the Ozias "cancer treatment" while in the employ of Ozias; he was employed by Baker to do the same kind of work when she came to Muscatine. Mrs. Turner had no medical training and was not even a registered nurse!

#### THE FIVE TEST CASES

Baker, on the witness stand, admitted that he broadcast over his radio station that he was going to investigate a cure for cancer (the Ozias "treatment") and that he "wanted five men or women from any part of the United States or Canada who were suffering from cancer to consent to become a test patient for this treatment, that I would pay all of their expenses for them, all doctor bills, nurses'

care, medical fee, room and board, and they to pay their own transportation to the hospital (in Kansas City, Mo.) where the treatment would be made." It developed that, as a matter of fact, most of the "test patients" paid their own expenses both in transportation and in fees to Ozias. These "test cases" were dealt with extensively in Baker's *T N T Magazine* and the matter was sent out as a reprint, because, according to Baker, the copies of his magazine containing the material had been sold out. The article was headed in black-faced type, *T N T Magazine Investigation Proves That Cancer Is Curable.* The article in question started as follows:

"Cancer is conquered. The greatest discovery in medical science in years—a positive cure for cancer, that dread disease which has taken toll of millions of lives, caused thousands to commit suicide and driven other thousands to insanity—has been revealed by an investigation conducted by Norman Baker, publisher of *T N T* magazine and owner of the Norman Baker Enterprises and radio station *KTNT*, who was assisted by a physician and member of his staff.

"Seeing is believing. Mr. Baker and his fellow investigators have seen with their own eyes enormous and malignant cancers in advanced stages of growth rapidly yield to a new and painless treatment, soften and disappear. They selected the cancer cases themselves for observation after they had determined beyond any doubt that they were authentic cases of cancer. They have watched these true cases of cancer under treatment and have seen the cancers grow smaller and pass away."

Baker then went on to state that "painstaking observation" of the cases that had been selected for the test had "thoroughly convinced Mr. Baker that cancer has been conquered." The article then goes into detail regarding the five test cases, reproducing photographs of the individuals concerned. Here it may be interpolated that all five of the patients are dead and were dead for some time before Baker ceased reprinting his article to prove that "Cancer is Conquered."

(To be concluded)

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## EDITORIALS

### The Swing of the Pendulum

For countless generations, probably since the medical twins Ars and Scientia were in their swaddling clothes, the pendulum of professional opinion has swung in a wide arc. There have always been forceful and opinionated men in medicine and always will be, for after all, the profession is made up of human beings with all their excellencies and all their failings. Luckily the forceful and opinionated not infrequently have promulgated doctrines which were essentially sound but, as in other fields of human endeavor, the faddists, with their one-track minds, have sometimes been the noisiest, the most articulate and the most positive. When these traits have been combined with persuasiveness these undesirables have not infrequently led the rank and file of the profession astray. In short, there have always been fashions in Medicine just as in spring bonnets, and the medical modes have sometimes been just as bizarre as the millinery. One has only to recall as striking examples the medicine of the Eighteenth Century with its flood of metaphysical speculations or the era of bleeding, blistering, purging and puking which ended barely a century ago.

Luckily the profession has always attracted some men with the true scientific spirit: keen, critical, and with a traditionally Missourian scepticism. These have leavened the mass to some extent but, in spite of them, there has always been a tendency for the pendulum to swing too far in some matters. Evidences of this can be found not only in medical literature but even in the graveyard. Did not the

great clinician Graves leave chiseled on his tomb stone "I fed fevers," obvious evidence that in his day most practitioners didn't? But, despite fads and fancies, there has always been a substantial substratum of practitioners with the saving grace of common sense and, needless to say, there have always been those with keen powers of observation and good judgment who have tempered prevailing ideas in the fire of experience. Furthermore, even in the most freakish eras, there have been those who made new and valuable discoveries.

There are one or two points to be noted in passing judgment on these common phenomena: first we must remember that new and important contributions in any science, and medicine is in part science, are, so to speak, in the air. Great discoveries rarely originate wholly anew in the mind of a single individual; there is a series of lesser but cognate observations which precedes them. Some alert and erudite thinker synthesises these observations and adds the spark which combines them into a new principle. Conversely it should be noted that the ordinary run of speculations and discoveries is limited by the knowledge of the time and this, of course, limits practical procedures based on them. Finally we have to deal with human nature, of which one cynic has remarked that "the only thing predictable about it is that it is unpredictable." Human beings, even those trained in science, are a curious mixture of credulity and skepticism. New remedies, for example, are at first usually embraced with enthusiasm and often misused, partly because



they are ballyhooed by advertising, and an advertising agent who does not deal in superlatives is almost as rare as the great auk. Then, with experience, comes a stage of reaction; unpleasant side effects are discovered, and finally, after months or more often years of experience, the true indications or the remedy are established.

It is interesting for one who has followed the progress of medicine for more than half a century to note how the pendulum of opinion swings from one extreme to the other. Take for example the question of the care and feeding of infants: the great-grandparents of the present generation of young mothers brought up their children more or less by guess and by gosh; their grandmothers relied on the admirable dicta of L. Emmett Holt; their mothers lived during the period of rigid formulae and feeding by time table, and now after a brief period of liberal infant feeding with almost anything but corn beef and cabbage, another *laissez faire* era begins to rear its head. But, after all, the results of these extreme pendular excursions are not all bad; each swing, leaves behind some modicum of new and valuable experience and, in the long run, it is better to have wide excursions than none at all.

G. B.

### A Significant Development

Periodic physical examinations of presumably healthy persons have long been advocated by public health associations and life insurance companies. The comparatively recent development of the so-called Detection Clinic as an aid in the early diagnosis of cancer is an attempt to answer a problem which is the concern of every practising physician and, also, to satisfy a public demand which is increasing in great proportion. In Connecticut two clinics of this kind are now functioning and their work has already demonstrated the usefulness of such endeavor, not only as an aid in the early diagnosis of malignancy but also in discovering other lesions in persons who are presumably healthy.

While it is true that all of the diagnostic procedures which are carried out in such clinics can be duplicated by the practising physician, certain laboratory tests, such as the cytologic test from the vaginal smear, require a special experience for their interpretation. Another diagnostic procedure which has been added by one metropolitan clinic is the fluoroscopic examination of the stomach in patients over 45 years of age without gastric symptoms, and

a complete g.i. series in patients with such symptoms. This same clinic recently has added as routine a proctoscopic examination and, in a total of 299 individuals without symptoms, there was an incidence of 5 cancers and 18 precancerous polyps. The establishment of such clinics represents a significant trend in medical practice and the response of the public in giving financial backing to such enterprise may be accepted as a measure of the great public confidence in medical science. This is a satisfying circumstance, but it must be accepted with a certain humility, for the part that physicians must play in future developments is a very real and demanding one.

In a recent report by Dr. E. S. L'Esperance on the role of the Prevention Clinics in the early diagnosis of cancer this author summarized this experience as follows:

"There are certain conclusions which are evident after ten years of this cautious experiment. The phenomenal growth illustrates conclusively the need of such routine periodic complete physical examinations as one of the most practical methods to meet the problem of cancer control and emphasizes the possibilities of preventive medicine. Furthermore, one of the important aspects of these clinics is the ability to allay the fear of cancer which may result in true cancerphobia. After a complete examination the statement that no evidence of cancer is found is one of the most valuable angles of our work."

### Our Aging Patients\*

The reduced mortality of infectious diseases in the past half century has greatly increased the number of elderly persons in the population. This trend was well under way in 1940 when 26.5 per cent of the American people were over forty-five. By 1980 it is estimated that 50 per cent will have reached this age. The specific implications of this population shift upon medical practice in the next ten years have recently been thrown into focus by C. Ward Crampton, chairman of the Subcommittee on Geriatrics and Gerontology of the Public Health Committee of the Medical Society of the County of New York. Crampton points out that geriatrics will never become a clearly delineated specialty, for older persons are subject to the same diseases as younger ones, and the services of all specialties except pediatrics are necessary for their treatment. Rather, an aware-

\*Crampton, C. W. "What Geriatrics Means to the Medical Profession." *New York Medicine*, 3:21-26, 1947.

ness of the special problems of older people becomes essential for all practitioners of medicine and surgery.

Crampton develops at some length the necessity for recognizing various kinds of aging. He emphasizes particularly the difference between chronological age and physiological age, the latter being dependent upon endocrine and metabolic factors, some of which are subject to modification. He also devotes attention to pathological processes, such as chronic foci of infection which may in some instances contribute to the aging process.

To understand the psychologic problem of aging is perhaps the most difficult step in attaining the geriatric point of view. Older persons are satisfied with very little. As instinctive drives of earlier years lose their force conflicts wane, and psychoneurotic symptoms tend to die away. On the other hand there is often a vague sense of insecurity and loneliness which is minimized by a familiar environment. Most physicians are well acquainted with the old codger who gets along fairly well with a family retainer in a dingy old Victorian monstrosity but who becomes delirious or paranoid in the sunny southwest corner of a sparkling clean but unfamiliar nursing home. The evaluation of senility is important to the geriatrically minded physician who often must decide upon the date of a patient's retirement. It is important to comprehend the mental state of a patient about to have a cataract operation or a prostatectomy, and it is essential to choose sedatives with caution lest they increase rather than allay restlessness. Bromides often accumulate in older persons with impaired renal function. Likewise the effects of diuretics must be observed, not upon urinary output alone, but also upon the mental state, which is often confused by too rapid dehydration.

It is easy to look upon older persons as "crocks" and difficult to comprehend the problems which they face. The middle aged physician or nurse has been through childhood and adolescence, so that these phases of life are not entirely foreign to the understanding. Geriatrics require imagination, and the physician who can apply this priceless quality to the care of older persons has an established future in service and personal success.

### Study the Chart

We publish in this issue a working chart showing in outline the mechanisms by which our State Society functions. A study of its content will reveal

a good many things which may not be apparent to some of our members. The chart points out, as has been emphasized recently by our President, that our State Medical Society is basically the eight County Medical Associations and it is through their delegates that the whole policy of the State Society is formed and it is to them that the Council is responsible. For this reason, contrary to what has sometimes been inferred, the Council does not inaugurate policy. Ideas affecting policy which may originate in the Council are referred to the House of Delegates. It may be with or without recommendation. The various committees which are listed should be carefully noted; also, the extrasociety organizations with which they are in intimate contact.

The chart is an impressive document in that it shows a great many activities and functions in which we, through our State organization, are performing for the betterment of Connecticut medicine. As we survey these multiform activities we are also impressed with the fine way in which the operations go on. For this reason we should pay proper tribute to those individuals who are giving so much time and effort at the center of our organization, not forgetting, however, those at the periphery whose loyalty is such that they can always be counted upon to give unselfishly. The chart, as shown, is a very useful piece of information. Its careful study is a satisfying experience.

### National Guard Medical Officers

The Connecticut National Guard is experiencing a critical situation in securing an adequate number of medical officers.

According to Colonel William B. Smith, Surgeon General, forty-five additional medical officers are required to fill present vacancies in the authorized tables of organization.

These new tables call for a total strength of 15,000 men and officers. This month 3,000 men and officers will be sent to Camp Edwards for field training, and members of the Air National Guard will train at Bradley Field.

What about medical officers for these encampments? The total enrollment of Connecticut physicians with the National Guard at the present time comprises four medical officers and one flight surgeon. Apart from the medical problems of current summer training, more serious problems exist in providing medical supervision for the state's military establishment as it continues to expand.



That this situation should exist in the aftermath of World War II is understandable, in view of the very human desire to forget the miseries of this great catastrophe. But it is our destiny to live for an indeterminate period in a trembling world. And the possibility that every individual may safely refrain from military participation is not yet a white cloud of hope on the international horizon.

Aside from the problems of national defense, however, the value to any state of a well organized and efficient National Guard has been demonstrated on many occasions. It is the only official state organization trained and equipped to cope with emergency and disaster. The services performed by the National Guard during Connecticut's 1938 hurricane disaster furnishes an excellent example of its value in this connection.

Recently the American Medical Association requested 50,000 returned medical officers to state their views concerning medicine and the military services. The response was far above the highest expectations, and displayed a deep interest among the more than 26,000 former medical officers who replied to the questionnaire.

But these questionnaires, valuable as they are, have only uncovered and emphasized the problems of military medicine. The only real answer medicine can give to the needs of military organization is to participate in its activities. Without such participation, medicine will have but a small voice in the solution of these problems.

Approximately one-third of Connecticut's 2,600 physicians served in the military and naval forces during the war. Those who have reentered the National Guard are all veterans, and it is likely that many more, realizing as they do the important role of military medicine, will again engage in peacetime military activities.

But these opportunities should not be accepted only by those who have experienced war service. All physicians qualified by age and physical status should consider seriously this possibility of gaining new knowledge in the field of military medicine, as a store against the day when such knowledge may become indispensable for the survival of our people.

### The New Indigents

A while back a new expression came into our vocabulary, it was, "medical indigent," and it usually

meant self-respecting and self-supporting people who could pay their way and wanted to accept when they were overtaken by more or less costly episodes of illness. On generally good reasoning the family income of \$2,500 was considered adequate in most localities and people below that level were talked about a good deal and some wholesome plans discussed to help them. Previous reasoning along this line is no longer quite valid because there is a group of new indigents largely made by the government and the increased cost of living and if present conditions continue a reassessment of income values must be made.

It only takes a little bit of figuring to see that old standards of family income are no longer adequate to meet many of the essential costs of existence. For example, in 1939 a family man with \$2,500 of income had a full \$2,500 of purchasing power after taxes. Today he has \$1,535. The family income of \$5,000 has shrunk to \$2,815 in terms of purchasing power and the 1939 income of \$10,000, which was considered generous, has now dropped in purchasing power to \$5,193 and that family is in the \$5,000 class of 1939.

These are pertinent figures when consideration is given to purchasing power, including medical care, housing, and all of the necessities of life.

### Early Ambulation

The value of bed rest in recovery from surgical procedures has long been recognized, but recent observations have shown that convalescence may be lengthened and serious complications may result from the injudicious prolongation of such confinement. Among the latter are atelectasis and pneumonia, thrombosis and embolism, and hollow viscus atony. Among the advantages of early ambulation may be mentioned accelerated healing of tissues, less asthenia, and the economic advantages of a shortened period of hospitalization, in some instances as much as five to seven days. The papers on this subject which are presented in this issue emphasize the fact that the profession as a whole must revalue the subject to the end that skepticism on the part of the patient, based on tradition, may not interfere with the carrying out of these newer procedures. It has been stated that the patient should have no more choice in the institution of early ambulation than he has in the selection of an anesthetic or a surgical procedure.

## THE PRESIDENT'S PAGE

**T**HE COSTS of medical care are many and diverse, and the physician's fee is but one of these.

The factors that promote good health are still more numerous. A partial list would include nutrition, shelter and clothing, hospitalization, nursing, medicines, wholesome recreation, steady habits of mind and body, and the ability to live in a complex society, joining our efforts with others for the common good.

Sir William Beveridge, universally known planner for social security from cradle to grave, has stated that medical care is not the most important element in his national health program. An inspection of this thought may not be flattering to the physician's ego. Although we can rightfully hold that the physician is the sine qua non of any sound health program, we must retain a true perspective of our relationship to all the forces which produce good health. This is essential for the continued progress of medicine.

Many physicians are concerned about the attempts that are made to magnify the role of the medical man as the chief factor in the high cost of sickness, to leap at the solution of the deeply involved problems of national health by the naive device of socialized medical care.

We should crystallize our concern into action and use it as a motivating force. We should all raise our voices in support of those who by their wisdom and energy seek to promote a sound social order wherein we can most effectively minister to the medical needs of our people.

James Raglan Miller, M.D.



FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET                      NEW HAVEN

TRUSTEES OF THE BUILDING FUND REORGANIZED

Five additional members have been added to the Board of Trustees of the Building Fund as voted by the House of Delegates at the Annual Meeting. Dr. Gold continues as Chairman of the Board and previously appointed members are: C. Charles Burlingame, Hartford; Cole B. Gibson, Meriden; Ralph W. Nichols, New Haven; George M. Smith, Pine Orchard. Newly appointed members are: Edmund L. Douglass, Groton; Raymond A. Gandy, Stamford; Michael E. Giobbe, Torrington; Donald J. McCrann, Hartford; Edward J. Ottenheimer, Willimantic.

Dr. Gold has divided the Committee into three Sub-Committees: Committee on General Solicitation, Dr. Smith, Chairman, Drs. Douglass, McCrann and Ottenheimer; Committee on Memorial Gifts, Dr. Nichols, Chairman, Drs. Gandy and Giobbe; Committee on Plans and Construction, Dr. Gibson, Chairman, Dr. Burlingame and ex officio, the Secretary of the Society.

The Board, with the cooperation of the Presidents of the County Associations, will make an intensive effort during the next few months to increase pledges to the Fund so that building may be started as soon as conditions warrant. As of June 1 contributions from members of the Society have been received as follows. In addition \$2,290 has been received from other sources.

	NUMBER MEMBERS	NUMBER CONTRIBUTED	PERCENTAGE OF MEMBERS CONTRIBUTING	AMOUNT
FAIRFIELD .....	547	234	42.8	\$14,799.00
HARTFORD .....	678	305	45.0	17,212.00
LITCHFIELD .....	95	39	41.0	3,035.00
MIDDLESEX .....	81	39	48.1	1,895.00
NEW HAVEN .....	699	264	37.8	19,841.00
NEW LONDON .....	131	59	45.0	5,470.00
TOLLAND .....	19	7	36.8	430.00
WINDHAM .....	49	22	44.9	1,442.00

It is estimated by the Board that additional contributions will be required to carry out the building program. Divided proportionately among the County Associations the additional quotas are:

Fairfield .....	\$12,551.00	New Haven .....	\$15,109.00
Hartford .....	16,688.00	New London .....	1,080.00
Litchfield .....	1,715.00	Tolland .....	520.00
Middlesex .....	2,115.00	Windham .....	1,008.00

The Roster

For the past several years it has been customary to publish the roster of members of the Society in this issue of the JOURNAL and the 1947 roster is published herewith. It carries the largest number of names ever included in the Society's roster and

because of the changes resulting from the return from military service there are many new names and addresses. Practically all members of the Society have now returned to civil life and for that reason all designations relating to military service have been omitted. The Secretary will appreciate being notified of the errors or additional changes in this roster.

Bound copies of this roster published separately from the JOURNAL are available at the Secretary's Office for a nominal charge.

### Committee on the Chronically Ill

The Society's new Committee on the Chronically Ill which was authorized by the House of Delegates at the Annual Meeting has been appointed and had its organizational meeting on July 14. The chairman of the Committee is George A. Wulp, Hartford, and other members are: Richard I. Barstow, Norfolk; A. Nowell Creadick, New Haven; Clifford D. Moore, Stamford; Charles H. Sprague, Bridgeport.

Dr. Creadick and Dr. Sprague bring unusual experience to this Committee. Dr. Sprague has for a long time been chairman of the Veterans Home Commission which operates the Rocky Hill Veterans Hospital, and Dr. Creadick for two years has been the chairman of the State Commission on the Chronically Ill. This Commission received nearly a million dollars from the 1947 General Assembly for the purpose of initiating the state program for the care of the chronically ill.

The Society's committee should be of great advisory service to the many public and voluntary agencies which are interested in the growing problem of care of the aging population.

### 1948 Annual Meeting

Joseph H. Howard, Bridgeport, who always seems willing to accept new responsibilities of service to the Society, has been named chairman of the Local Committee on Arrangements for the 1948 Annual

Meeting which, according to present plans, will be held in Bridgeport next May. The last meeting in Bridgeport was in 1944.

### Connecticut Medicine Speaks

During June three officers of the Connecticut State Medical Society spoke before as many different societies in New England. James R. Miller, president, addressed the New Hampshire Medical Society at its annual meeting in Newcastle on Internal Public Relations in Medicine. Creighton Barker, secretary, was one of three guest speakers at the annual convention of the Connecticut Pharmaceutical Association at New London. Stanley B. Weld, editor-in-chief of the JOURNAL, outlined to the House of Delegates of the Maine Medical Association at York Harbor the prerequisites for a successful state medical journal.

### Dr. Morriss Honored

William H. Morriss, medical director at Gaylord Farm Sanatorium, was presented with a silver bowl and twin candelabras at the annual meeting of the Gaylord Farm Association in July. David R. Lyman, M.D., superintendent at the sanatorium, made the presentation in recognition of twenty-five years of service rendered by Dr. Morriss. At the same meeting Thomas P. Murdock, M.D., of Meriden, was elected vice-president of the Association and, in addition to Dr. Murdock, Wilder Tileston, M.D., and Milton C. Winternitz, M.D., were elected to the board of directors.

## THESE GAVE

### CONTRIBUTORS TO THE BUILDING FUND, APRIL TO JULY, 1947

#### FAIRFIELD COUNTY

Amos, I. L., Danbury  
Davol, Rector T., Greenwich  
Laszlo, Andras E., Bridgeport  
Rosenberg, Saul, Bridgeport  
Uvitsky, Irving H., Bridgeport

#### HARTFORD COUNTY

Cragin, Donald B., Hartford  
Lamoureux, Eugene E., Hartford  
Shulman, David N., Hartford  
Warring, Howard L., Hartford

#### NEW HAVEN COUNTY

Birnbaum, Hyman B., Madison  
Green, Jacques H., Waterbury  
James, Mary L., Waterbury  
Koster, Leo W., West Haven  
Liebow, Averill A., New Haven  
Riesman, John P., Branford  
Scholl, Robert F., New Haven  
Shure, A. Lewis, New Haven  
Spencer, Susan B., Madison  
Timm, Alexander B., Jr., Milford

#### LITCHFIELD COUNTY

Cleary, Harold J., Watertown

#### MIDDLESEX COUNTY

Nelson, Walter N., Cromwell

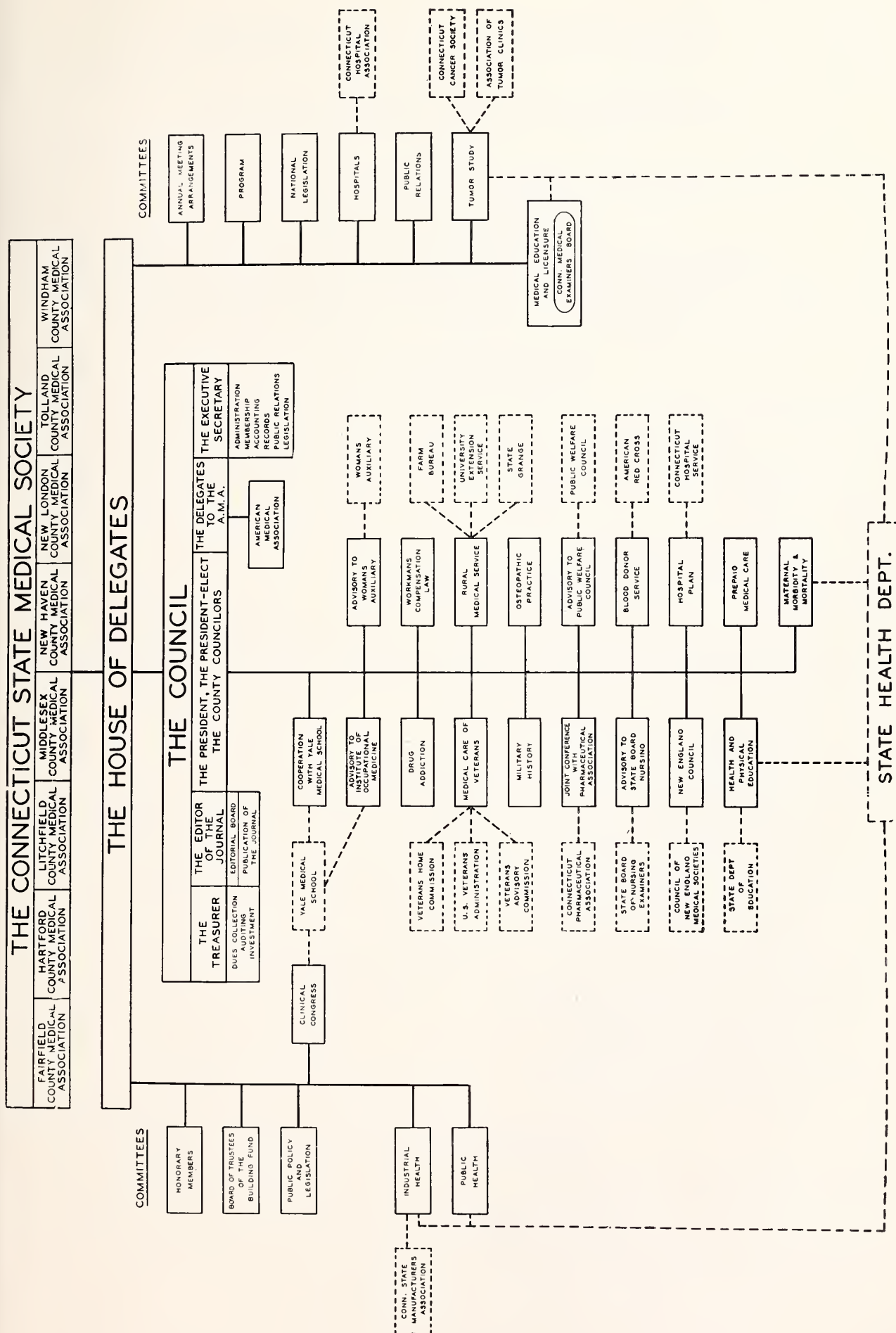
#### NEW LONDON COUNTY

Callahan, John W., Norwich  
Irwin, Harold H., New London  
Manwaring, Ier J., Norwich

#### WINDHAM COUNTY

Dayton, Neil A., Mansfield  
Margolick, Moses, Putnam  
Woodworth, John A., Moosup





TWENTY-SECOND CLINICAL CONGRESS  
 OF THE  
 CONNECTICUT STATE MEDICAL SOCIETY  
 AND THE  
 YALE UNIVERSITY SCHOOL OF MEDICINE

September 16, 17, 18, 1947

The morning presentations will be given in the auditorium of the Yale University School of Law, and the afternoon panels and symposia will be held in the amphitheaters of the New Haven Hospital and the School of Medicine.

Tuesday, September 16

- 10:00 TREATMENT OF ANURIA  
E. L. Pratt, *New Haven*
- 10:15 THE ADVANTAGES OF MULTIPLE SULFONAMIDE THERAPY  
William T. Salter, *New Haven*
- 10:30 VAGOTOMY IN THE TREATMENT OF PEPTIC ULCER  
Lester Dragstedt, *Chicago*
- 11:00 PSYCHIATRY IN A GENERAL HOSPITAL  
Ralph M. Kaufman, *New York*
- 11:40 RESULTS OF THE COOPERATIVE CLINIC STUDY OF THE TREATMENT OF SYPHILIS WITH PENICILLIN  
Frank W. Reynolds, *Baltimore*
- 12:10 THE TREATMENT OF NEUROSYPHILIS  
Raymond D. Adams, *Boston*
- 2:30 PANEL DISCUSSION ON SURGICAL TREATMENT OF PEPTIC ULCER  
Samuel D. Kushlan, *presiding*  
PANEL DISCUSSION ON TREATMENT OF SYPHILIS  
Allen K. Poole, *presiding*  
SYMPOSIUM ON DIARRHEA IN INFANCY  
Daniel C. Darrow, *presiding*
- 3:45 PANEL DISCUSSION ON PSYCHIATRY IN THE GENERAL HOSPITAL  
Burness E. Moore, *presiding*  
SYMPOSIUM ON OCCUPATIONAL DISEASE  
Ronald Buchan, *presiding*  
PRESENTATION OF SURGICAL CASES  
Samuel C. Harvey, *presiding*

Wednesday, September 17

- 10:00 EPIDEMIC RINGWORM OF THE SCALP  
Samuel Peck, *New York*
- 10:30 USE OF THE VAGINAL SMEAR IN THE DIAGNOSIS OF CANCER  
Howard Ulfelder, *Boston*



- 11:00 CONGENITAL ANOMALIES CAUSING OBSTRUCTION IN THE GASTRO-INTESTINAL TRACT  
Orvar Swenson, *Boston*
- 11:40 THE DIAGNOSIS OF OPERABLE CONGENITAL CARDIOVASCULAR ANOMALIES  
Ruth Whittemore, *New Haven*
- 12:10 THE TREATMENT OF THYROTOXICOSIS  
James Howard Means, *Boston*
- 2:30 PANEL DISCUSSION ON DIAGNOSIS OF UTERINE CANCER  
Carl Johnson, *presiding*
- SYMPOSIUM ON THE TREATMENT OF CONGENITAL CARDIOVASCULAR ANOMALIES  
Harris B. Shumacker, Jr., *presiding*
- SYMPOSIUM ON THYROTOXICOSIS  
William B. Salter, *presiding*
- 3:45 THE ANTIBIOTICS IN RELATION TO THE SKIN  
Maurice J. Strauss, *presiding*
- PANEL DISCUSSION ON "ROOMING IN FOR MOTHERS AND INFANTS"  
Edith B. Jackson, *presiding*
- MOTION PICTURE—"TO HEAR AGAIN"  
Norton Canfield, *presiding*

### Thursday, September 18

- 10:00 BRUCELLOSIS  
Wesley Spink, *Minneapolis*
- 10:30 BOECK'S SARCOID  
I. Snapper, *New York*
- 11:00 LIVER FUNCTION TESTS  
Franklin M. Hanger, *New York*
- 11:40 RATIONALITY IN THE TREATMENT OF ANEMIA  
William Dameshek, *Boston*
- 12:10 PSYCHOTHERAPY IN GENERAL PRACTICE AND IN PSYCHIATRIC PRACTICE  
John M. Murray, *Boston*
- 2:30 PANEL DISCUSSION ON INFECTIOUS DISEASES  
Francis G. Blake, *presiding*
- PANEL DISCUSSION ON LIVER DISEASE  
Gerald Klatskin, *presiding*
- SYMPOSIUM ON PSYCHOTHERAPY  
F. C. Redlich, *presiding*
- 3:45 SYMPOSIUM ON PULMONARY GRANULOMAS  
Kirby Howlett, Jr., *presiding*
- PANEL DISCUSSION ON ANEMIA  
Theodore S. Evans, *presiding*
- MOTION PICTURE AND DISCUSSION ON REGENERATION OF VISION  
Leon Stone

## Dr. Barker Elected President of Connecticut Cancer Society

Dr. Creighton Barker, the Society's executive secretary, was elected president of the Connecticut Cancer Society at the organization's annual meeting Monday evening, June 23, at the New Haven Lawn Club. He will assume his new duties September 1, succeeding Dr. A. Nowell Creadick, of New Haven, now completing his third year as president of the cancer group.

The organization elected as its vice-president Professor Ira V. Hiscock, chairman of the Department of Public Health at Yale University School of Medicine. Miss Grace Mooney, executive assistant of the State Medical Society, was re-elected secretary, and Mr. Charles F. Lewis, of Waterbury, was re-elected treasurer.

Dr. Creadick was elected a member of the executive committee, as were also Dr. Joseph H. Howard, of Bridgeport; Dr. Alfred L. Burgdorf, Hartford; Dr. Ralph T. Ogden, Hartford; Dr. Edward J. Ottenheimer, Willimantic; and Dr. N. William Wawro of Hartford. Other members elected to the committee were Mrs. Douglass O. Burnham, Woodbury; Miss Katherine Jackson, New Haven; Mrs. Wallace Wessels, Hartford; Mr. James W. Cooper, New Haven; Mr. Harry F. Morse, New London; and Mr. A. M. Wade, of Greenwich.

Guest speakers at a dinner following the business session were Dr. Roscoe S. Spencer, president of the National Cancer Institute, Bethesda, Maryland, and Dr. Howard W. Haggard, director of the Department of Applied Physiology, Yale University School of Medicine.

Speaking on recent developments in cancer research, Dr. Spencer declared that "No other disease problem has created such a widespread interest among non medical investigators." He attributed the acceleration of cancer research to the generous financial support provided by public and private funds and the deep interest of workers in experimental biology and medicine.

"In the course of a few decades," the cancer specialist stated, "I believe that the generous support of the public for cancer research will be justified by the results, perhaps by the by-products alone."

Dr. Haggard admonished the public for its complacent attitude regarding "so-called natural death," and pointed out that "the doctor cannot be expected

to fight alone—he must have strong popular support." He declared that fundamental research in cancer is still in an early stage of development, and that "the way ahead is long and devious."

Mr. Harry F. Morse, campaign chairman, announced that the organization had appreciably exceeded its 1947 quota of \$277,440 by raising a total campaign fund of more than \$330,000. At the business session a proposal to consolidate the society's state office, now located in Waterbury, with the New Haven campaign office resulted in authorizing the president to appoint a committee to further study the problems involved and report its findings at the fall meeting of the organization. Approximately 150 delegates from local cancer groups throughout the state attended the meeting.

## Physicians Appointed to State Commission

Dr. Joseph H. Howard, of Bridgeport, and Dr. Joseph I. Linde, of New Haven, have been appointed by Governor James L. McConaughy to a commission to inaugurate a \$7,000,000 improvement program for the state's mental institutions.

Other members appointed to the commission include Dean Albert E. Waugh, University of Connecticut; Mr. Frederick U. Conard, West Hartford; Mrs. Corinne R. Alsop, Avon; Mr. Raymond I. Longley, Stafford Springs; and Mrs. Alice P. Merritt, Hartford.

In announcing the appointments, Governor McConaughy emphasized that commission members were selected for their interest and active support in programs for the care of the chronically ill, the mentally ill, and the aged.

Dean Waugh, chairman of the board at the Norwich State Hospital, and head of the economics department at the University of Connecticut, is a member of the Joint Commission of State Mental Hospitals. Dr. Howard, past president of the State Medical Society, is a member of the State Commission on the Care and Treatment of the Chronically Ill, Aged and Infirm. Also a past president of the State Medical Society, Dr. Linde is Health Officer for the City of New Haven, and a member of the State Tuberculosis Commission.

President of the Niles-Bement-Pond Company, Mr. Conard is a trustee of the Fairfield State Hospital. Mr. Longley served in the last two sessions of the Legislature, and is a member of the Joint Commission on Training Schools and a trustee at



the Mansfield Training School and Hospital. Mrs. Merritt, the state's first woman senator, is also a member of the Joint Commission on State Mental Hospitals, and a member of the Board of Directors of the Connecticut State Hospitals. Having served three years in the House of Representatives, Mrs. Alsop has long been active in public health and welfare.

The seven-member commission was appointed under a law originally enacted by the Legislature to create an institutional building program commission, charged with surveying all of the state's humane and welfare institutions, and to report by January 1, 1949. However, in the closing days of the 1947 legislative session public pressure for more funds for the institutions resulted in an appropriation of approximately \$7,000,000.

Governor McConaughy has announced that the commission will not wait until 1949 to recommend specific projects, but will take immediate steps to improve the state institutions. Its objectives include a comprehensive survey with special reference to overcrowding, fire hazards, water supplies, and heating. The commission will also study the adequacy of treatment for special classes of patients, such as the senile and tubercular. The first meeting of the commission was held with the Governor on June 23.

### **New Britain Medical Group**

Seven New Britain physicians have organized Connecticut's first medical-practice group. To be known as the New Britain Medical Group, the new organization began functioning on June 2.

Offices have been established at 32 Grove Hill, the former residence of Mrs. Florence Gates Judd. The property was recently purchased by the group, which is represented by the law firm of Ericson, Politis, and Gleason. The group membership comprises Dr. Donald A. Bristoll, obstetrics and gynecology; Dr. Bliss B. Clark, surgery; Dr. Louis W. Daley, otolaryngology; Dr. George P. Perakos, internal medicine and gastro-enterology; Dr. John C. White, internal medicine and cardiology; Dr. Dwight E. Wilson, urology; and Dr. Emmett C. Rankin. All members of the American Medical Association, the physicians forming the group are associates on the staff of the New Britain General Hospital.

### **Major David H. Clement Cited**

The United States of America Typhus Commission Medal has been awarded to Major David H. Clement, MC-AUS, of New Haven, Connecticut. The citation read as follows: He rendered meritorious service as surgeon in charge of the United States of America Typhus Commission ward in the 116th Evacuation Hospital at Dachau, Germany, from May 10 to June 10, 1945. Major Clement's devoted supervision of the care of patients suffering from endemic typhus and his scrupulous attention to the management of therapy with immune serum and with para-aminobenzoic acid contributed directly to humanitarian service and to the improvement in methods of treatment of typhus fever. Dr. Clement graduated from Harvard Medical School in 1935 and entered the military service in 1941.

### **Dr. Pratt Honored by Harvard**

Aaron P. Pratt, M.D., of Windsor was awarded the degree of Master of Public Health at the commencement exercises at Harvard in June. Dr. Pratt is a graduate of Harvard Medical School, also of Harvard University School of Public Health. He graduated from the latter before receiving his degree of doctor of medicine. During World War I he served in the U. S. Army Sanitary Corps.

### **Dr. Powers Elected Head of Pediatrics Society**

Grover F. Powers, professor of pediatrics at Yale University School of Medicine and pediatrician in chief at Grace-New Haven Community Hospital, was elected president of the American Pediatrics Society at its recent annual meeting. Dr. Powers has been a member of the faculty at Yale since 1921, and a full professor since 1927.

### **Bridgeport Engages Medical Social Worker**

Mrs. Fanita J. Smith, well known director of medical social work at Bridgeport Hospital, has now been engaged by Bridgeport Cancer Society as Director of its program. Bridgeport is proceeding with plans for a Detection Center along with a much more comprehensive program of Education and Service than in the past.

## Cancer Handbook for Dentists

The dentists in Connecticut have long registered an interest in being part of the active cancer program. As a result of their interest, the facts that would be helpful to them in detecting cancer of the head and neck have been highlighted in a handbook prepared by the dental and medical groups in cooperation with the state department of health.

This handbook is primarily a treatise on tumors of the oral cavity and adnexa. The approach is through the dental examination—an approach which is common to all in the dental profession and one which they have so ably developed that it is universally routine in its occurrence.

The publication is divided into six chapters as follows: the cancer problem in Connecticut, dental examinations, cancer of the skin, tumors of the oral cavity and adnexa, biopsy and treatment.

The first chapter deals with the cancer problem in Connecticut indicating the incidence of the disease as it occurs in the head and neck. It also carries a list of available state aided cancer centers and consultation services to which the dentist can refer suspected cases for diagnosis and treatment.

The chapter on dental examinations stresses the necessity for careful technique and history taking "that can be followed and thus become a fixed working habit." The reason for this is stated thus: "the opportunity for examination of patients by the dentist both clinically and roentgenographically, in many instances several years before they may present themselves for examination by a physician, is an opportunity for the dentist to aid in the early recognition and diagnosis of cancer, particularly primary cancer of the mouth." A hard and fast rule is stated in this chapter. "Lesions which do not heal after ten days of treatment, or which heal for a short period only to again ulcerate in a few days, should be suspected of being cancer. In all such chronic lesions biopsy is mandatory."

In discussing cancer of the skin and tumors of the oral cavity and adnexa a sincere attempt is made to emphasize the duty of the dentist as well as the physician to secure prompt and efficient treatment for these lesions, particularly in the early stages. Neoplasms have been classified as benign tumors and cancers. A tumor is a mass of new tissue which persists and grows independently of surrounding structures and which has no physiological use. A cancer

is a malignant tumor characterized by its ability to invade surrounding tissues and to metastasize to distant parts through the vascular and lymphatic systems. These lesions are classified by type and by location with which the dentist most frequently comes in contact.

In the chapter on biopsy emphasis is placed upon correct technique and the importance of this procedure for obtaining a definite diagnosis. This chapter points to the urgent need for early diagnosis and prompt treatment for upon these two factors depends the success or failure of subsequent procedures.

In the treatment of cancer stress is placed upon those measures the dentist can institute to improve oral hygiene. Under methods of treatment considerable comment is made upon x-ray therapy, its use and the dangers attached to improper or insufficient dosage. The book concludes with this pertinent statement—"In the final analysis one is forced to conclude that the time honored phrase 'early diagnosis and treatment' offers the most immediate hope of progress in the control of cancer. When and adequate facilities are available for early diagnosis and treatment of this disease and the public is so informed that they make the best use of these advantages, we may expect to see improvement in the situation as regards cancer."

Half tones and four color process plates will more than adequately illustrate the text and are considered one of the finer features of the handbook.

Contemplated date of publishing about October 1, 1947 for distribution by the Connecticut State Dental Association, The Connecticut Cancer Society, and The Connecticut State Department of Health.

## Analysis of Postwar Questionnaire

The American Medical Association announces that former medical officers may receive a copy of the recently published "Analysis of the Postwar Questionnaire" by writing directly to Frank G. Dickenson, PH.D., director of the AMA Bureau of Medical Economic Research, 535 North Dearborn Street, Chicago 10, Illinois.

Comprising 28 pages, the analysis contains information obtained from more than 26,000 replies to the questionnaire. Approximately 50,000 questionnaires were mailed during the survey.



## In Maine

The same ocean was seen lapping the beach at York Harbor, Maine, and breaking over the rocks on either side as had been viewed rolling in along the shore at Atlantic City only a few days before. Gathered in the comfortable Marshall House the Maine Medical Association registered over 200 members, in addition to many wives and children. The first day was given over to a session of the House of Delegates and an evening meeting addressed by Edward F. Steegen, associate administrator of the National Physicians Committee. Sectional conferences filled the following two forenoons with scientific sessions each afternoon. Guest speakers were present from Philadelphia and Boston and subjects presented by several prominent Maine physicians.

At the dinner meeting on the second evening the medical program of the Veterans Administration was outlined by Winthrop Adams, M.D., of Boston. Miss Esther Lipton of the State Department of Education fascinated her audience with an account of her work as supervisor of the special education program for handicapped children. At the final dinner meeting fifty year medals were presented to nine physicians. The program ended with a masterly address on Salvaging the Modern Mind by J. Seelye Bixler, president of Colby College. Dr. Bixler warned that the trend to magnify the irrational state of life that found its culmination in the worship of blood, race and soul shows signs of reappearing and is strengthened by the presence of widespread fear. Physicians can help save the modern mind from the currents of unreasonableness that are about to overwhelm it," Dr. Bixler said. It was encouraging to hear one of New England's leading educators express his belief that it is absurd to suppose that men were placed on this planet merely to develop a society that should spend its best energies working on means for its own destruction. "If physicians who know about both sickness and health and the relation between the two will help us to act like normal reasonable beings," said Dr. Bixler, "they will contribute not merely to us as individuals but to the society whose problems loom so large today."

The elements conspired to give the Association's annual golf tournament a wet time. Maine physicians number many good golfers, not the least being the president of the Maine State Golf Association. So wet were conditions that day that Lady Luck had to come to the rescue of one player whose club left the tee almost the same moment as his ball. The result, a one foot putt for a birdie.

One of the strongest of Maine's medical organizations is its Medico-Legal Society. Dr. A. Warren Stearns of Boston, formerly dean of Tufts Medical School, entertained its members with an account of the life and crimes of that famous character, Jesse Harding Pomeroy. In his discussion Dr. Stearns appealed for a more realistic allocation of legal medicine in the medical school curriculum and a differentiation by physicians between compulsive crimes and insanity. The successful use of the lie detector and of a compact apparatus for measuring the alcohol content of the breath were described by Le-Moyne Snyder, M.D., medico-legal director of the Michigan State Police. The interest of Maine physicians in medico-legal problems has resulted in a well deserved leadership in this field.

The hospitality of our northern neighbors contributed much to a pleasant visit. Many old friends were greeted again and the presence of several former Hartford interns added to the occasion.

Peripateticus

## The Heart and Pregnancy

Hamilton\* has recently summarized the activities of the cardiac clinic at the Boston Lying-In Hospital for the twenty-five year period from 1921-1946. During that time 76,125 women were treated by the hospital through pregnancy, and 1,335 (1.8 per cent) of the pregnancies occurred in women with heart disease. At the inception of the clinic the maternal mortality rate in cardiac patients was 20 per cent; three years later it was 5 per cent; and subsequently it has been 3 per cent or under. The abrupt fall at the outset indicates the effect of introducing modern cardiac therapy at that time. In the past twenty years there has been a gradual lowering of maternal mortality from other causes. Between 1921 and 1936 cardiac disease contributed 14 per cent of all maternal deaths; from 1937-1946, 28 per cent.

The 1,335 pregnant cardiac patients included 1,244 with chronic rheumatic heart disease (93 per cent); 69 with congenital cardiovascular defects (5.2 per cent); and 22 with miscellaneous cardiovascular diseases.

Rheumatic heart disease constituted the major problem. It was present in 1.6 per cent of all the

\*Hamilton, Burton E.: "Report from the Cardiac Clinic of the Boston Lying-In Hospital for the first twenty-five years." *Am. Heart J.* 33:663-668, 1947.

pregnant women, and patients with this disorder had a maternal death rate of 3.8 per cent. Hamilton found it desirable to subclassify patients with rheumatic heart disease into "favorable" and "unfavorable" categories. Classified as favorable were those women with minimal (or more than minimal) signs of rheumatic heart disease who were able to carry on moderate activity without having heart failure. During the last ten years of the survey "favorable" cases of rheumatic heart disease had a maternal mortality of 2 per cent and an infant mortality of 8.6 per cent. The "unfavorable" cases had a maternal mortality of 18 per cent and an infant mortality of 31 per cent. These figures are of the same order of magnitude as the ones which prevailed in the first fifteen years of the study. Congestive heart failure caused 64 per cent of the deaths in the "unfavorable" group, but only 12 per cent in the "favorable" category. It caused 39 per cent of all the deaths attributed to rheumatic heart disease in both groups. Bacterial endocarditis and embolism together accounted for 35 per cent. Twenty-six per cent of the deaths were attributed to miscellaneous factors.

The maternal mortality for 69 patients with congenital cardiovascular defects was 2.9 per cent. Patients with patent ductus arteriosus fared very well, and there were no deaths among women with coarctation of the aorta. Ventricular septal defects were less well tolerated, for several mothers had serious circulatory disturbances after delivery, and one died. One woman with tetralogy of Fallot survived six pregnancies.

During the twenty-five year period numerous direct measurements were made of the physiologic changes in the circulation attributed to pregnancy (venous pressure, circulation time, vital capacity, plasma volume, etc.). As the result of these studies it was possible to conclude that the cardiac "load" is relatively unchanged from the non pregnant state until the sixth calendar month of pregnancy. At that time it rises steeply to about 50 per cent above normal and maintains this level until the ninth calendar month when it drops to approximately one half the greatest rise.

The fall of cardiac load during the ninth calendar month has led to abandonment of premature delivery by hysterotomy in cardiac patients. It is considered safer for the woman to be delivered at term when the "load" has shown its maximal fall. Most women are delivered from below. Hysterotomy is employed only for obstetrical indications.

The Cardiac Clinic at the Boston Lying-In Hospital has served a valuable function in crystallizing the problems of pregnant cardiac patients. In the next twenty-five years more patients with surgically treated congenital lesions will live into the child bearing period. New information is accumulating in regard to the role of hormones in edema formation. New viewpoints and methods of approach will continue to make the study of cardiovascular disease in pregnancy a fascinating and a practical pursuit.

### Recommendations of American Hospital Association

The American Hospital Association has just completed a study of federal and non federal hospital planning. Out of this study have come recommendations aimed to bring about a closer coordination between the two groups and these recommendations are being sent to all members of Congress and to hospital and health authorities.

Before any planning can be done, the report points out, Congress must decide whether it wants a separate hospital system for veterans or wishes to consider care for the population as a whole on the most economical and effective basis. The report recommends that an authoritative agency be created by Congress. This agency, with the advice of recognized federal and non federal hospital authorities would set up a method for integrating all hospital planning. The analysis which would be necessary would reevaluate planning of federal hospital systems so that they could be related to the planning provided in the Hospital Survey and Construction Act. The agency would be charged with the responsibility of recommending the methods by which federal funds should be invested in the future to provide the highest quality of care uniformly to all people throughout the country on the most economical basis.

### Ratifications of WHO Constitution

Albania and Saudi Arabia have recently ratified the Constitution of the World Health Organization. This brings the number of ratifications to fourteen nations, of which ten are members of the United Nations. Twenty-six ratifications by members of the United Nations are required for the establishment of the World Health Organization as a specialized agency of the United Nations.



## THE FIRST MAN ON YOUR DOORSTEP



Relations with the public start with the first man on your doorstep. Regardless of who he is, his opinions are worth a great deal—because he is the only instrument provided by Nature to implement the thoughts and hopes of man.



When the man on the street begins to tell his friends and neighbors—then public opinion crystallizes. Written words can only state opinions—it takes eyes, ears, tongues, and legs to make them completely effective.

Public Relations Are  
Relations With People

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

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PUBLIC  
AFFAIRS**Cash Sickness Benefits for Railroad Workers**

The following information concerning sickness benefits for railroad workers is reprinted from the May 17 issue of the *Journal of the American Medical Association*. Physicians desiring further information should communicate with Mr. Daniel L. Uffner, branch manager, Railroad Retirement Board, 242 Orange Street, New Haven.

A cash sickness benefit system for railroad workers began operating throughout the nation on July 1. These benefits were added under the 1946 amendments to the Railroad Unemployment Insurance Act and provide partial compensation for wage loss due to disability on the same basis as that due to unemployment. The system will be administered by the Railroad Retirement Board, which administers the Railroad Unemployment Insurance Act.

All disabilities which prevent railroad employees from working, regardless of how or where they occur, are covered under the program. In the first year of operations, about 300,000 of the 2,075,000 railroad workers qualified are expected to receive benefits, and the total amount of benefits is expected to reach \$36,000,000.

A physician's statement of sickness will be required before claims can be paid. It is believed that the program will require about 650,000 medical examinations a year. Employees are free to choose their own doctors, and any physician to whom an employee goes for examination or treatment may supply the information required as initial proof of an employee's claim.

The forms on which medical information will be requested from a physician are the "Statement of Sickness" and the "Supplemental Doctor's Statement." The first mentioned form is intended primarily to obtain information at the beginning of each illness, and the second is intended to obtain additional information only when such information is

needed later on in the same illness. The statements are designed to furnish, as simply and as conveniently as possible for the physician, the minimum information required for Board purposes.

The "Statement of Sickness" on which the medical evidence is to be furnished must be mailed to the appropriate office of the Railroad Retirement Board within seven days after the first day claimed as a day of sickness, or the employee may lose part of his benefits. Claims for succeeding fourteen day periods may be allowed for a predetermined period as indicated by the medical evidence on the doctor's initial statement, but in continuing illnesses supplemental information about the patient's illness may also be requested from the physician.

Claims will be filed and adjudicated in the regional offices of the Railroad Retirement Board. These offices are located in Atlanta, New York, Cleveland, Chicago, Dallas, Kansas City, Minneapolis, Denver and San Francisco and serve the adjoining territories. Each will have a physician who will act as a medical consultant.

**Superior Court Rules on Issue of Pregnancy**

The Superior Court has upheld an administrative appeal from the Unemployment Commissioner's ruling in declaring a certain claimant who was pregnant ineligible for benefits. The claimant left her employment because she was unable to perform her duties due to pregnancy, but later, while still pregnant, registered for work and filed for benefits when her pregnant condition no longer interfered with her ability to work.

The Assistant Attorney General noted "the first legislative recognition that pregnancy raises a unique problem in job placement came in 1939 when a new subdivision was added to the disqualified section setting up a bar during the last two months of pregnancy . . . and because this proved to be



adequate to meet the problem posed by pregnancy . . . the 1941 Legislature amended the disqualification and extended the bar during the entire period of pregnancy." He also declared pregnancy to be an incident of domestic life, thus excluding pregnant women as properly members of the industrial labor market.

In his decision the Assistant Attorney General held that the claimant left her job on account of pregnancy and when she applied for benefits was still pregnant. "Her unemployment," he stated, "is therefore due to pregnancy and she is ineligible for benefits. Whether or not her physical condition is such that she is able to work is, in case of a pregnant woman, expressly declared by statute to be immaterial."

### Nation Wide Scientific Attack Launched on Problem Drinking

Announcement has been made of the first large scale nation wide attack on problem drinking by the Research Council on Problems of Alcohol, an associated society of The American Association for the Advancement of Science.

Organized ten years ago, The Research Council has been working quietly and energetically in sponsoring individual research projects among leading scientific institutions to get at the fundamental causes of problem drinking, which affects the lives of over 750,000 people in the United States. The primary objective of the Council is to learn more about these fundamental causes and to develop effective methods of treatment and prevention.

With the publication of the booklet, "The Problem Drinker, A Frank Discussion of How the Problem of Uncontrolled Drinking May Be Solved by Medical Science," spearheading a nationwide campaign to raise \$200,000 a year initially, The Research Council hopes to establish a series of research diagnostic treatment centers in leading medical schools and their affiliated hospitals throughout the country.

One of the first of these centers has already been established at the Cornell University Medical College—The New York Hospital under a grant of \$150,000 covering a five year period. A chain of such centers, The Research Council feels, will provide many of the answers and much of the services needed to cope with this much neglected medical problem.

## NEWS FROM WASHINGTON

Two bills, S1454 and S1455, have been introduced into the Senate to amend the Public Health Service Act, the first in regard to certain matters of personnel and administration, the second to provide grants to postgraduate schools of public health. These have been referred to the Committee on Labor and Public Welfare. Two similar bills have been introduced in the House and referred to the Committee on Interstate and Foreign Commerce.

S1355 to amend the Social Security Act to enable states to establish more adequate public welfare programs has been referred to the Committee on Finance. A companion bill, HR3636, has been introduced in the House and referred to the Committee on Ways and Means.

HR3464, a bill to provide for the mobilization of the scientific resources and knowledge of the United States for the purpose of seeking the cause and cure of cancer, heart disease, infantile paralysis, and other diseases of mankind, has been referred to the Com-

mittee on Interstate and Foreign Commerce. This measure establishes a medical research agency governed by a board of five, nominated by the President, one of whom shall be the Surgeon General. The Board shall have a Director at \$18,000 per annum. The agency is authorized and directed to initiate, conduct and support scientific research in cancer, rheumatic fever, Bright's disease, diabetes, diseases of the heart and other major diseases, and to investigate the cause and spread of infectious diseases. An initial appropriation of five million dollars is authorized.

Also HR3762 has been introduced in the House and referred to the same committee. This bill provides for research relating to diseases of the heart and circulation and will aid in the development of more effective methods of prevention, diagnosis, and treatment of such diseases, and for other purposes. Fulfilling one of his campaign pledges, Mr. Javits, the author of HR3762, introduced the bill establishing in the Public Health Service a National Heart

Disease Institute and creating a National Heart Disease Council. The Institute shall make grants in aid for research projects, train personnel in matters pertaining to heart diseases and assist states in the prevention, diagnosis and treatment of heart diseases. The Council will be composed of the Surgeon General, Chief Medical Advisor of the Veterans Administration, Surgeon General, Army and Navy, and twelve members appointed by Surgeon General, U.S.P.H.S.

S140 amended has been reported in the Senate by the Committee on Expenditures in the Executive Department. This bill known as the Taft-Fulbright bill is a compromise embracing the spirit of S712, the Aiken bill. As it now reads, the Federal Security Agency is to be elevated to Department status. It incorporates the view of a majority of the witnesses that the Under-Secretaries of Health, Education and Public Welfare need not be professionally trained in their respective fields.

Through the efforts of Honorable Everett Dirksen, Representative from Illinois, the House has inserted in the appropriation for the Atomic Energy Commission a provision earmarking \$25,000,000 for research in connection with control of cancer. The Atomic Energy Act authorizes the Commission to exercise its powers in connection with research into matters pertaining to health, and it is believed that progress already made justifies continued activity in this field to combat this increasingly menacing disease. This move may eliminate the need of enacting special legislation in this field.

### Request Prosecution of Isidore Falk

Representative Harness, chairman of the House Subcommittee on Publicity and Propaganda, has requested Attorney General Tom C. Clark to prosecute Isidore S. Falk, director of the Bureau of Research and Statistics of the Social Security Administration, for breaking the Federal law against lobbying. House Report No. 786 brings out the fact that Federal funds have been used for the purpose of influencing legislation before Congress. The report deals "exclusively with activities calculated to build up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance referred to by witnesses and publications as the Wagner-Murray-Dingell bill."

### Secretary Farrell of R. I. Society Honored

On June 12 Providence College bestowed the honorary degree of Doctor of Science upon one of its own alumni, John E. Farrell of Providence, executive secretary of the Rhode Island Medical Society and managing editor of the *Rhode Island Medical Journal*. John Farrell's career has been a brilliant one and fully justifies the decision of the corporation and faculty of Providence College in their selection of him for this signal honor.

Following his graduation from Providence College Mr. Farrell accepted the position of graduate manager of athletics at his alma mater. In addition to this he was a member of the faculty in the department of English for four years. In 1938 Mr. Farrell resigned his posts at Providence College to become the first executive secretary of the Providence Medical Association. Five years later he moved over to a similar position with the State Medical Society and in addition became managing editor of the *Rhode Island Medical Journal*.

The list of John Farrell's accomplishments in the field of health education is a long one. He has attained prominence as an authority on medical economics and health education problems. His activities have not been confined to the medical societies which have employed him but have reached out to the Council of Social Agencies, to the Governor's Advisory Council on Health, to the Boy Scouts of America, the Providence Chamber of Commerce, the Crippled Children and Adults of Rhode Island, the Children's Heart Association, the American Red Cross, and the Woman's Field Army for the Control of Cancer.

Mr. Farrell's many friends in Connecticut offered him their hearty congratulations. Although not a doctor of medicine, John Farrell has contributed much to the cause of medicine and to the welfare of his fellowmen.

### Dr. Hawley To Receive Gorgas Award

Dr. Paul R. Hawley, chief medical director of the Veterans Administration who was officer-in-charge of all medical care in the European Theater of Operations during World War II, has been awarded the Gorgas Award for 1947.

The award is given annually by the executive council of the Association of Military Surgeons to some person who has made a notable contribution



in the field of military medicine. It is sponsored by Wyeth, Incorporated, of Philadelphia.

The presentation will be made at the association's annual meeting in Boston, November 13-15.

Dr. Hawley, who retired from active duty with the Army on June 30, 1946 with the rank of Major General, is a native of Indiana. He had a long and distinguished career in the Army and has an impressive medical background.

### **New Surgeon General of U. S. Army**

The nomination has been confirmed of Brigadier General Raymond W. Bliss as Surgeon General of the Army to succeed Major General Norman T. Kirk whose term expired May 31. General Bliss, a native of Massachusetts, graduated from Tufts College Medical School in 1910 and was commissioned

first lieutenant in the Medical Reserve Corps the following year and in the Regular Army in 1913 on graduation from the Army Medical School. Following his graduation from Tufts General Bliss served an internship at the Hartford Hospital. Later he entered Harvard Medical School for special study in surgery, remaining in Boston for further clinical study and instruction at Harvard until 1921. He has served as chief of surgery at Sternberg General Hospital, Manila, P. I., at Fort Sam Houston and at William Beaumont General Hospital, El Paso, Texas. Early in the recent war he was a military observer in London, then became surgeon of the First Army and Eastern Defense Command in 1942, and the following year was assigned to the Surgeon General's Office as chief of operations and Assistant Surgeon General. He was appointed Deputy Surgeon General in January 1946. During World War I General Bliss made extensive tours of the European, Mediterranean and Pacific areas, and was an observer at the atom bomb test at Bikini. He has been awarded the Legion of Merit, the Distinguished Service Medal, the French Legion of Honor and the Award of the Italian Crown.

### **Army Engineers to Build Greatest Medical Center**

What is planned to be the greatest medical research center in the world will be built at Forest Glen, Maryland, by the Corps of Engineers for the Office of The Surgeon General, according to a recent announcement made by Major General Raymond W. Bliss, The Surgeon General. In keeping

with technological advances in all fields, based on experiences in the late war, the center will be equipped to anticipate and meet the medical problems of the future as well as to cope with those of the present. The initial cost is estimated at approximately \$40,000,000. Construction will be supervised by the District Engineer, Washington, D. C., Engineer District.

Officially designated as the "Army Medical Research and Graduate Teaching Center," the project will consist of a 1,000 bed general hospital, capable of expansion to 1,500 beds; the Army Institute of Pathology building; the Army Medical Museum and Center Administration building; Central Laboratory Group buildings; and the Army Institute of Medicine and Surgery. A working library, animal farm, quarters for the staff and other buildings are included in the plans.

Located just outside of Washington, the new Army Medical Center will have the advantage of close relationship to the Walter Reed General Hospital, the Naval Medical Center, the medical schools of the District and the proposed new Washington Medical Center, with all of whom ideas can be interchanged. In addition, members of the District of Columbia Medical Society, among them some of the finest specialists in the world, and medical experts from other Government departments, will be available for consultation. The Center will also cooperate with the National Bureau of Standards, the National Institute of Health and the National Research Council.

Plans for the 1,000 bed hospital building, as announced by the Army Engineers, provide that 200 beds shall be specifically designated as research beds and that these be so located as to be physically accessible to research activities of the various institutes and central laboratories. However, they will remain an integral part of the hospital for service and patient care. In the proposed future expansion, a proportionate number of beds will be reserved for research and these will be located in the same area as the original 200, with the same accessibility to other buildings. Any expansion would be horizontal rather than vertical, making this arrangement possible.

Arrangement and equipment of the hospital will embody the most modern criteria developed as a result of war experiences. As a part of the Army's chief medical center, the hospital will have access to all ideas for new equipment which will be adopted

as fast as it is tested and developed. In addition to regular hospital facilities, the plans call for a gymnasium, bowling alleys, swimming pool, auditorium and conference room, post exchange, barber shop, snack and beverage bar, post office, library, bank, game rooms and tailor shop. These would be included in, or directly connected with, the hospital building and would be accessible to patients and post personnel.

The estimated total floor space for the initial building is 650,000 square feet, and this includes the additional features listed above. When the hospital is expanded to 1,500 beds, it is estimated that it will require 825,000 square feet of floor space.

### Aviation Medicine Course Announced

The recall of twenty Medical Corps Reserve Officers annually for a period of ninety days, for the purpose of attending a course of instruction and training in Aviation Medicine was recently announced by the War Department.

The course of instruction which is being presented under the technical supervision of The Air Surgeon at the AAF School of Aviation Medicine, Randolph Field, Texas, covers a study of the fundamentals of Aviation Medicine with a special emphasis placed on the principles and practice of medicine as applies to aviation and the efficient performance of the "64" physical examination for flying. Each graduate will receive a certificate designating him an Aviation Medical Examiner.

Eligibility for the course requires the applicant to be under forty years of age, meet minimum physical requirements for flying, and have an efficiency index of 4.0 or above, and not currently designated a Flight Surgeon or Aviation Medical Examiner. He must possess a real interest in Aviation Medicine and a desire to become an Aviation Medical Examiner. The physical examination may be obtained at most Army Air Force stations or an examination by any Flight Surgeon or Aviation Medical Examiner is acceptable.

The first class will begin October 6 and extend through December 12, 1947. Government quarters will be available at Randolph Field for students enrolled in the course. Facilities will not permit quarters for dependents.

Applications for this training should be made by letter, accompanied by a copy of the WD AGO

64, "Physical Examination for Flying," to the Office of The Surgeon General, Attention: Military Personnel Division, by not later than August 15, 1947.

### Request for More Accurate Reporting of Accidental Deaths

A request that physicians cooperate in furnishing more complete information in death certificates when death is due to accidental means is contained in a circular letter recently issued by the State Department of Health.

The circular points out that frequently items 20a through 20f contain only partial information when the certificates are filed. Since tabulations based on these data are widely used by the National Safety Council and affiliated local organizations, the information supplied in paragraph 20 is essential for proper classification, the circular states.

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## THE DOCTOR'S OFFICE

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Isadore L. Amos, M.D., of 323 Main Street, Danbury, has announced that he will limit his practice to general surgery, gynecology and obstetrics.

Henry Applebaum, M.D., announces the opening of an office in Wilton in addition to one in Norwall.

F. Wellington Brecker, M.D., announces the opening of his offices at 955 Asylum Avenue in the Westwood Building, Hartford, for the practice of dermatology.

S. Francis DiLorenzo, M.D., has opened an office for the practice of medicine at 195 Grove Street, Waterbury.

Milton Carl Fleish, M.D., announces the opening of his office at 64 Garden Street, Hartford. Practice limited to care of infants and children, children heart disease.

James H. Linder, M.D., has opened an office for the practice of urology in Sharon.

Joseph I. Epstein, M.D., announces the opening of an office at 118 Main Street, Middletown, for the general practice of medicine.

William M. Stahl, Jr., M.D., announces the opening of an office in Danbury with his father for the practice of medicine.



# MEDICINE AND THE VETERAN

COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*  
 EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven  
 JOSEPH N. D'ESOP, New Haven

## Monthly Fee Limitation Rescinded by VA

The recently announced ruling limiting monthly payments to physicians participating in the medical-care plan for veterans to \$500 has been rescinded, according to the Hartford Regional Office of the Veterans Administration.

The change in the ruling does not affect the maximum per annum compensation, which remains at \$6,000 during a fiscal year, July 1, 1947 to June 30, 1948, and thereafter.

Physicians who recently received notices in their mail concerning the original ruling are requested by the administration to disregard the monthly limitation stated therein.

## Medical Society and Pharmaceutical Contracts With VA Renewed

The contract between the State Medical Society and the Veterans Administration to provide home-town medical care for Connecticut veterans has been renewed for one year, and became effective July 1.

It has also been announced by the Veterans Administration that its contract with the Connecticut Pharmaceutical Association has been renewed for the same period.

The Hartford Regional Office of the administration has called the attention of all participating physicians to the procedure necessary to enable veteran patients to secure their prescriptions at participating pharmacies, as listed elsewhere in this issue.

The procedure is as follows:

- a. An original written prescription on your regular printed prescription form is required.
- b. Prescriptions must bear the date written and also the name and address of the veteran.
- c. A certificate stating "I am authorized to treat and prescribe for the above named Veterans Administration patient" must appear over your signature.

## Time Extended for Reinstatement of Government Insurance

The Veterans Administration has announced that the reinstatement privileges now in effect for National Service Life Insurance will be extended to January 1, 1948.

Until this announcement was made, World War II veterans who had allowed their wartime NSLI term policies to lapse for a period of more than three months had only to August 1 to reinstate them without physical examination.

The VA explains that any World War II veteran whose government insurance has lapsed may renew the policy simply by certifying that he is in as good health as he was at the time of lapse, executing the required applications, and paying two monthly premiums.

## Veterans Disability Compensation for Malaria

Veterans drawing disability compensation for malaria may have their payments terminated unless evidence of a recurrence or relapse is submitted to the Veterans Administration within fourteen months following establishment of their claims.

This warning is contained in a memorandum published by the Connecticut Veterans Reemployment and Advisory Commission, dated July 8.

The memorandum reads: "Twelve months after it has been officially determined that the veteran suffers from service-connected malaria, the Veterans Administration will request him to submit, within sixty days, evidence of a recurrence or relapse. When such evidence is submitted, the veteran's service connected rating for malaria will be extended for an additional year from the date of the last attack. Veterans should be advised to report to a physician every time a relapse occurs, and to obtain from him a statement indicating that the attack was malaria and the treatment given."

## Public Health Service Veterans Eligible for G.I. Benefits

Commissioned officers of the United States Public Health Service who are honorably discharged veterans of World War II, and who have reentered the public Health Service are eligible for benefits under the G.I. Bill.

A memorandum recently published by the Connecticut Veterans Reemployment and Advisory Commission points out that an executive order effective July 29, 1945, declares that the entire commissioned corps of the Public Health Service was considered to be a military service during the war. Qualified officers of the Public Health Service are therefore entitled to education, training, loan guarantees, and other benefits of the G.I. Bill on the basis of active service with the Army, Navy, or Coast Guard outside the continental limits of the United States, or in Alaska, according to the memorandum.

## New VA Hospital in Boston

President Truman and the Federal Board of Hospitalization have approved the acquisition of a nine-acre site for a Veterans Administration hospital in Boston. VA will construct a 1,000 bed general medical and surgical hospital on the Boston site, located three miles from the city's business district. The site, known as "The House of the Angel Guardian," is sufficiently close to Boston's three medical schools to assure cooperation of local medical personnel as consultants, attendings and residents.

VA explained that the site is being substituted for a previously approved site on Willow Pond Road in Boston. Legislation enabling VA to acquire title to the Willow Pond Road site was not enacted. Therefore it was necessary for VA to select an alternate location for its proposed hospital.

## Total Veteran Count

At least 16,000,000 veterans will come out of World War II, according to the latest Veterans Administration estimate.

This includes the veterans discharged by the armed forces through June 30 and the soldiers, sailors, marines and others still in service on the same date.

VA said the potential veteran population will increase until the official termination of the war, which has not been declared yet. This is true because the

potential figure will include persons entering the armed forces until the war is declared ended.

Thus, the 16,000,000 figure for June 30 is the minimum potential veteran population of World War II.

By comparison, World War I produced 4,627,000 veterans; the Civil War, 1,849,000 Union Army veterans, and the Spanish-American War, 381,000 veterans. This makes a combined total of 6,857,000 for the three wars, or considerably less than one half of the minimum estimated for World War II alone.

## Pharmacists Enrolled in VA Program

For the information of physicians active in the home-town medical care program for Connecticut veterans, the following list of pharmacists enrolled in the program has been obtained from the Connecticut Pharmaceutical Association by the Committee on Medical Care of Veterans. Supplementary lists will be published as they are made available by the association:

- Schoonmaker Pharmacy (George J. Barnico)  
410 Main Street, Ansonia
- Avon Pharmacy (S. W. Gordon)  
Main Street, Avon
- Baltic Pharmacy (J. A. Baril)  
Baltic
- English Drug Co. (Charles J. and E. Ambrose English)  
138 Greenwood Avenue, Bethel
- Bloomfield Pharmacy (Joseph Barnett)  
17 Tunxis Avenue, Bloomfield
- Ambrose Pharmacy (Fred E. Ambrose)  
3811 Main Street, Bridgeport
- Capitol Drug Co. (Herman Perillo)  
2508 Main Street, Bridgeport
- Clinton Pharmacy (Louis W. Glass)  
1196 State Street, Bridgeport
- Ethical Pharmacy (Sidney Greenspan)  
1260 Main Street, Bridgeport
- Freeman Pharmacy (Abraham Freeman)  
1739 East Main Street, Bridgeport
- Gerstl Pharmacy (Arpad Gerstl)  
1367 Boston Avenue, Bridgeport
- Greenspun's Pharmacy (Julius Greenspun)  
1557 Fairfield Avenue, Bridgeport
- Heaphy Pharmacy (William A. Heaphy)  
319 Wood Avenue, Bridgeport
- Hertz Drug (Orrin Hertz)  
1998 Boston Avenue, Bridgeport
- Long Hill Pharmacy (W. E. Brownell)  
R. F. D. No. 4, Bridgeport
- Murray Pharmacy (Harry Horin)  
1703 Park Avenue, Bridgeport
- Pembroke Pharmacy (Morris F. Bukofsky)  
1326 Pembroke Street, corner Stillman, Bridgeport



- Spaner's Pharmacy (Leslie E. Spaner)  
588 North Avenue, Bridgeport
- Willow Pharmacy (Ray J. Buccino)  
1717 Barnum Avenue, Bridgeport
- Kauttu's Pharmacy (Carl E. Kauttu)  
Main Street, Canaan
- Collins Pharmacy (Ernest Collins)  
Chester
- Gurian Pharmacy (Harry Gurian)  
Colchester
- Bell Pharmacy (Albert E. Belisle)  
1 Tokeneke Road, Darien
- Grieb's Darien Pharmacy (Robert C. Grieb)  
184 Post Road, Darien
- Lee Drug Co. (Anthony J. Szczesiul)  
249 Main Street, Derby
- Chatham Pharmacy (E. C. Hitchcock, Jr.)  
78 Main Street, East Hampton
- Elm Pharmacy (Joseph Dubitzky)  
39 Burnside Avenue, East Hartford
- Granniss Corner Pharmacy, Inc. (Anthony J. Fiondella)  
418 Forbes Avenue, East Haven
- Holcombe Drug Co. (Philip Amarante)  
259 Main Street, East Haven
- Metcalf Pharmacy (Nathan Cohen)  
284 Main Street, East Haven
- Glenbrook Phmcy. (Frank C. Gross & Philip C. Varnum)  
324 Hope Street, Glenbrook
- Thames Pharmacy (Albert C. Amato)  
Groton
- Douden's Pharmacy (Frank F. Douden)  
57 Whitfield Street, Guilford
- Centerville Pharmacy (Charles Edward Crook)  
2361 Whitney Avenue, Hamden
- Cherry Hill Pharmacy (John T. Dziubinski)  
1830 Dixwell Avenue, Hamden
- Country Club Pharmacy (N. H. Hamerman)  
1235 Whitney Avenue, Hamden
- Highwood Pharmacy (Harry A. Flaxman)  
828 Dixwell Avenue, Hamden
- Prospect Pharmacy (Andrew E. Vena)  
51 Helen Street, Hamden
- Taft Pharmacy (Joseph Jacob)  
127 Treadwell Street, Hamden
- Euclid Pharmacy (Hyman I. Cohen)  
679 Blue Hills Avenue, Hartford
- Fabian Drug Co. (John R. Fabian)  
527 Farmington Avenue, Hartford
- Harris Pharmacy (William Harris)  
519 Albany Avenue, Hartford
- Netherlands Pharmacy (James G. Trifiro)  
20 Farmington Avenue, Hartford
- Palmer's Pharmacy (Frank G. Palmer)  
Asylum Street, Hartford
- Parent-Rexall Drug Co. (Sidney E. Arenson)  
569 Park Street, Hartford
- Ray's Pharmacy (Raymond Hurwitz)  
410 Garden Street, Hartford
- Carey's Pharmacy (Charles R. Carey)  
62 Main Street, Jewett City
- Pevner's Pharmacy (Oscar Pevner)  
92 Main Street, Jewett City
- Marley Pharmacy (K. V. Driscoll)  
West and Meadow Streets, Litchfield
- Hyde Drug Co. (Robert L. Doane)  
Madison
- Monroe's Pharmacy (Harold N. Dinerstein)  
Madison
- Center Pharmacy (Edward W. Brown)  
487 Main Street, Manchester
- Quinn's Pharmacy (Walter B. Quinn)  
873 Main Street, Manchester
- Weldon Drug Co. (J. H. Sandols)  
901 Main Street, Manchester
- Broderick & Curtin Pharmacy (D. F. Broderick)  
42 East Main Street, Meriden
- Lynch Pharmacy (Raymond M. Lynch)  
298 East Main Street, Meriden
- Philip's Pharmacy (Philip Shapiro)  
171 Broad Street, Meriden
- United Cigar-Whalen Stores Corp. (Stanley J. Czaja)  
2 Colony Street, Meriden
- Milford Pharmacy (Manlius Y. Petrucci)  
1 New Haven Avenue, Milford
- Liggett Drug Co. (James E. Burger)  
360 Main Street, Middletown
- Murphy's Pharmacy (Joseph A. Murphy)  
644 Main Street, Middletown
- Pelton's Pharmacy (Benjamin Weitzman)  
Middletown
- Naugatuck Drug Co. (George J. Donovan)  
1 North Main Street, Naugatuck
- Windt Pharmacy (Ernest Windt)  
23 Elm Street, New Canaan
- Axelrod's Pharmacy (M. A. Axelrod)  
New Britain
- City Pharmacy, Inc. (Stanley J. Samcrajizyk)  
487 Main Street, New Britain
- Curran & Pajewski Pharmacy (Sidney G. Curran)  
Broad Street at Grove, New Britain
- Davis Pharmacy (A. N. Davis)  
1 Main Street, New Britain
- Park Street Pharmacy (M. London)  
223 Park Street corner Meadow, New Britain
- Reynold's Pharmacy (William G. Reynolds)  
35 Lawrence Street, New Haven
- Whitney Pharmacy (A. H. Cohen)  
374 Whitney Avenue, New Haven
- Alden Pharmacy (William T. Cadwell)  
243 Alden Avenue, New Haven
- Beck's Pharmacy (A. A. Breunig)  
543 Howard Avenue, New Haven
- Beck, A. M., Pharmacy (A. M. Beck)  
801 Edgewood Avenue, New Haven
- D'Andrea's Pharmacy (Michael S. D'Andrea)  
844 Elm Street, New Haven
- Deegan Hope Drug Co. (James J. Marrinan)  
596 State Street, New Haven
- El Dorado Pharmacy (Louis M. Jacobson)  
1147 Chapel Street, New Haven
- Eudowe Pharmacy (Saul W. Eudowe)  
1177 Chapel Street, New Haven
- Goldberg Pharmacy, Inc. (Murray Abraham)  
183 Oak Street, New Haven

- Grand Pharmacy Co. (William Fusco)  
309 Grand Avenue, New Haven
- Hall-Benedict Drug Co., Inc. (Edward N. Benedict)  
767 Orange Street, New Haven
- Hope's Drug (William J. Nolan)  
341 Grand Avenue, New Haven
- Humphrey Pharmacy (John J. Wozniak)  
880 State Street, New Haven
- Ideal Pharmacy (David H. Brussel)  
137 Newhall Street, New Haven
- Kane's Pharmacy (James H. Kane)  
287 Dixwell Avenue, New Haven
- Liggett Drug Co. (Henry E. Hastings)  
742 Chapel Street, New Haven
- Liggett Drug Co. (Elwood C. Thompson)  
871 Chapel Street, New Haven
- Mayfair Pharmacy (Louis Goldfarb)  
416 Whalley Avenue, New Haven
- Norton Pharmacy (Abraham J. Matloff)  
2 Norton Street, New Haven
- O'Brien, J. L., Pharmacy (John L. O'Brien)  
665 Grand Avenue, New Haven
- Roger Sherman Pharmacy (P. C. Ierardi)  
382 Whalley Avenue, New Haven
- Sachem Laboratories, Inc. (Marvin Botwick)  
197-199 Whitney Avenue, New Haven
- Cook, Harry H., Pharmacy (Harry H. Cook)  
West Greenwoods Road, Norfolk
- Cooper's Pharmacy (Julius Cooper)  
143 West Main Street, Norwich
- Leone Pharmacy (Daniel C. Leone)  
50 Main Street, Norwich
- Mara's Pharmacy (Irving R. Vogel)  
14 Franklin Street, Norwich
- Utle & Jones Pharmacy (Julius S. Cooper)  
60 Broadway, Norwich
- Mercier Pharmacy (Raymond E. Mercier)  
Railroad Avenue, Plainfield
- Conklin Pharmacy (R. H. Conklin)  
Portland
- Chicoine Pharmacy (Omer J. Chicoine)  
171 Providence Street, Putnam
- Riverside Pharmacy (Arthur Stroffolino)  
Post Road, Riverside
- Metcalf Pharmacy (Burton L. Bennett)  
12 East Main Street, Rockville
- Foley Drug (Edward F. Foley)  
11 Main Street, Seymour
- Ideal Pharmacy (John Palonsky)  
Corner Connecticut Ave. and Cedar St., So. Norwalk
- Liggett Drug Co. (Christian DeFelice)  
78 Washington Street, South Norwalk
- Fournier's Pharmacy (Aime E. Fournier)  
59 Main Street, Stafford Springs
- Bedford Drug Co. (Louis O. Levine)  
269 Bedford Street, Stamford
- Liggett Drug Co. (G. F. Stevens)  
180 Atlantic Street, Stamford
- Syl-May Drugs (John Gianvito)  
37 Bank Street, Stamford
- Connors, Francis J., Pharmacy (Francis J. Connors)  
77 Main Street, Stonington
- Hausman's Pharmacy (Robert Hausman)  
590 Success Avenue, Stratford
- Benoit's Pharmacy (Lawrence B. Benoit)  
Taftville
- Doyle's Pharmacy (M. W. Doyle)  
237 South Main Street, Torrington
- State Drug (Paul A. Salerno)  
Uncasville
- Modern Pharmacy (Saul Rabinowitz)  
Wallingford
- Park's Pharmacy (C. Clayton Parks)  
Washington Depot
- Apothecaries Hall Co. (Edward J. Carrington)  
86 Shelley Street, Waterbury
- Baldwin Pharmacy (Stephen Grosch)  
125 Baldwin Street, Waterbury
- Bendler's Pharmacy (John William Bendler)  
2 Congress Avenue, Waterbury
- Chase Park Pharmacy (Frank Calvo)  
890 West Main Street, Waterbury
- Dunphy's Pharmacy (William J. Dunphy)  
Waterbury
- Liggett Drug Co. (Lawrence R. Farrell)  
1 East Main Street, Waterbury
- Martin's Pharmacy (Daniel F. Martin)  
345 Meriden Road, Waterbury
- Paul's Pharmacy (George P. Paul)  
697 East Main Street, Waterbury
- Pickett, W. H. Drug Co. (Frank Guba)  
738 North Main Street, Waterbury
- Prospect Pharmacy (Pauline Milenky)  
39 Prospect Street, Waterbury
- Walnut Pharmacy (Francis A. Czarzasty)  
Waterbury
- Westside Pharmacy (Gustav Jabs)  
11 Watertown Avenue, Waterbury
- Waterville Pharmacy (Oscar A. Derowin)  
1583 Thomaston Avenue, Waterville
- Dougherty Drug (Francis B. Cole)  
135 South Main Street, West Hartford
- Center & Parkview Pharmacy (Edward Carofano)  
567 Campbell Avenue, West Haven
- 207 Orange Avenue, West Haven
- Coughlan's Pharmacy, Inc. (William J. Coughlan, Sr.)  
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- Silver Pharmacy (William H. Silver)  
519 Campbell Avenue, West Haven
- Achorn's Pharmacy (Frank L. Achorn)  
11 East State Street, Westport
- Dorain Pharmacy (Paul Zadoff)  
47 Main Street, Westport
- Brett Pharmacy (Jacob Brettschneider)  
465 Main Street, Willimantic
- Wilson Pharmacy (Joseph A. Fitzgerald)  
Willimantic
- Opera House Pharmacy (Albert Decsi)  
444 Main Street, Winsted



## CORRESPONDENCE

### Present Day Treatment of Carcinoma of the Face — Accepted Therapy

*A letter to the Editor from*

WILLIAM B. SWARTS, M.D., *Greenwich*

In the June 1947 issue of the CONNECTICUT STATE MEDICAL JOURNAL an article<sup>1</sup> appeared in which dogmatic conclusions of present treatment of cancer of the face are not in agreement with men who daily treat many of these cases.

The first point in the summary was that treatment of all types of carcinoma of the face is radical local excision. If this was the prevailing practice, then vast numbers of cured patients have been wrongly treated. The treatment of any kind of a malignant lesion is the destruction of all abnormal cells and whether one does this by irradiation, electro-surgery, excision, or combination of these methods, is a matter of judgment and training of the individual physician treating a case which has been thoroughly individualized.

For years, dermatologists have been using a method of destruction combining electro-surgery, curettage and roentgen ray therapy. In support of the success of this method Elliott and Wilton<sup>2</sup> reported 1,052 cases with a cure rate of 97.1 per cent for five years or longer. This method is simple and is done in the office without use of hospital facilities which are necessary for scalpel surgery, which is a point in these days of over-burdened hospital facilities. Also, from the psychologic and economic viewpoint, the patient is quickly and adequately treated without all the elaborate details necessary to plastic surgery. The wound and the resulting inconspicuous scar can be very carefully watched for recurrences; and these can be adequately controlled as the patient returns for follow-up treatment.

Recently Mohs<sup>3</sup> has reported on a new method for the microscopic excision of certain accessible forms of cancer after application of chemical fixatives. His work is so successful that the University of Wisconsin Medical School has seen fit to form a department of chemo-surgery. I have personally seen examples of cured patients by this method where the cancer was uncontrollable by either radiation or surgical excision.

I cite these various other methods, besides excision, of treating cancer of the face because they are being used successfully in "the present day treatment of carcinoma of the face."

The second point in the summary was that the treatment for squamous cell carcinoma of the ear, lip or intra-oral cavity is wide local excision with removal of the lymph bearing areas, whether nodes are palpable or not. This rather broad statement is open to criticism. I do not think that the radical procedure is necessary for many squamous cell epitheliomas which are external to the oral cavity. Many elderly patients develop multiple squamous cell epitheliomas in a senile skin which metastasize relatively late. Should a patient with a beginning intra-epidermic squamous cell epithelioma of the ear lobe be subjected to such a radical procedure? There is no arbitrary method of treating squamous cell epithelioma—again it may be any one or a combination of accepted methods, depending on the training of the physician and the individual study of the case. Certainly one would treat according to age of patient, location and histological report of the lesion.

I agree with the third point in the summary that malignant melanomas should be excised. However, it should be stated that roentgen and radium therapy have their place in treatment, especially if there is evidence of metastases.

Cosmetic results should always be considered secondary to curative results. With the combination of electro-surgery, curettage and radiation, the scars are small and become very inconspicuous. Even the most fastidious patients seem to be satisfied with the end results.

I do not believe one should exclude radiation therapy as a treatment for carcinoma of the face. MacKee and Cipollaro<sup>4</sup> state that there is very little difference in the results obtained by surgery or by irradiation. However, they do believe that when a combination of methods is used in treating carcinoma of the skin, there is a higher percentage of successes. Present day roentgen therapy is carefully measured by exact physical methods. It is unfortunate that the untoward results of pioneer x-ray therapists, who have paved the way for modern treatment, have their cases used as a contraindication to an accepted method of treatment.

It was unfortunate that such a biased article of one clinic was presented to the medical profession of Connecticut where, in the organization of various tumor clinics sponsored by the State of Connecticut

Department of Health, the cooperative efforts of the various specialists is held to be essential for the proper care of patients with accessible cancers.

#### REFERENCES

1. deCholnoky, T.: Cancer of the Face, Remarks on Present Day Treatment, Connecticut State Medical Journal, Vol. XI, No. 6, p. 434, June 1947.
2. Elliott, J. A., and Welton, D. G.: Epithelioma: Report on 1,742 treated patients. Arch. Derm. and Syph. 53:307 (April) 1946.
3. Mohs, F. E.: Chemosurgical Treatment of Cancer of the Nose: Microscopically Controlled Method. Arch. Surg. 53:327-344 (September) 1946.
4. MacKee, G. M., and Cipollaro, A. D.: X-rays and Radium in the Treatment of Diseases of the Skin, ed. 4, pp. 567, Philadelphia, Lea and Febiger, 1946.

### From the Anesthesiologists

To the Editor:

July 1, 1947

Enclosed is a copy of a resolution adopted by the Board of Directors of this Society at a meeting held in Atlantic City on June 11, 1947. At the time of its adoption, I was directed by the Board to send a copy of that resolution to the secretary of each State Medical Society. We hope that you will give it such publicity as is consonant with your policies and use it in such other ways as you may see fit. If you, for any reason, need additional copies of this resolution, I shall be glad to furnish them to you.

If at any time this Society or I personally, can be of any service to you, we will appreciate it if you will call upon us. We want to cooperate with you and your Society in every way possible.

Sincerely,

John H. Hunt,

Executive Secretary

Resolution Adopted by the Board of Directors of  
The American Society of Anesthesiologists, Inc.

June 11, 1947, Atlantic City, New Jersey

WHEREAS, the development and furtherance of modern Anesthesiology is of great importance to the welfare of patients and

WHEREAS, Anesthesiology is a component part of the practice of medicine:

NOW THEREFORE BE IT RESOLVED: That the American Society of Anesthesiologists, Inc., recommends strongly

A. The establishment of departments of Anesthesiology in all medical schools and hospitals under the

direction of a doctor of medicine actively engaged in the practice of Anesthesiology.

B. That the department of Anesthesiology shall bear the same relationship to the medical school and/or hospital as is borne by other medical departments of the institution.

AND BE IT FURTHER RESOLVED: That The American Society of Anesthesiologists, Inc., disapproves

A. Of the training of persons other than doctors of medicine in the science and art of anesthesia, for the assumption of responsibility in the care of patients where it may be necessary to exercise medical judgment, and particularly does it disapprove of the issuance of certificates for such training by its members.

B. The existence of departments of Anesthesiology in hospitals and/or medical schools under the direction of persons other than doctors of medicine or under the nominal direction of doctors of medicine not actively engaged in the practice of Anesthesiology.

### Physician Needed

Jackman Station, Maine

June 24, 1947

To the Editor:

We hope that you may be able to help us. Our present doctor will be leaving us within a month, in order to specialize, and when I explain the position our town is in you will understand why this is a very frightening thing.

Jackman is separated, by fifty miles of forest in every direction, from all other towns which have physicians. The nearest hospital is in Greenville, fifty miles away. In the winter the road to Greenville is generally impassible, and we must either wait for a train to take us there, or drive seventy-five miles to Skowhegan. I do not know where there is another community as far removed from medical care as our own will be after our doctor leaves.

We must have a doctor here.

It seems to many of us that if a description of our predicament *could be placed in your Society's publication*, it might attract the attention of some doctor we could not otherwise hope to reach. I am here enclosing a full description, and have no way of telling you how greatly we would appreciate your placing it properly for us.

Yours sincerely,

Mrs. Joan Ferland,

Jackman Station, Maine



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## HARTFORD

Mrs. Donald H. Cragin, 1414 Asylum Ave.  
Mrs. Edward H. Crosby, 252 Edgewood  
Mrs. Timothy L. Curran, 15 Owen  
Mrs. William Daly, 242 Edgewood St.  
Mrs. Michael J. DeVito, 232 Fairfield Ave.

Mrs. Asa J. Dion, 207 Washington  
Mrs. Walter J. Duksa, 55 Inlay  
Mrs. Benjamin H. Gottesfeld, 4 Vernon  
Mrs. Albert R. Keith, 201 North Oxford  
Mrs. Irving Krall, 22 Evergreen Ave.  
Mrs. Edward R. Lampson, 175 North Beacon  
Mrs. Arthur B. Landry, 128 Collins  
Mrs. John F. McGrath, 65A Webster  
Mrs. Nicholas A. Marinaro, Cedarcrest Sanatorium  
Mrs. Abraham M. Schaefer, 473 Hillside Ave.  
Mrs. David H. Schuman, 907 Albany Ave.  
Mrs. A. Frederick Serbin, 265 Blue Hills Ave.  
Mrs. Daniel Shea, 137 North Whitney  
Mrs. Louis Spektor, 26 Hughes  
Mrs. Peter J. Steincrohn, 176 North Beacon  
Mrs. John C. Wienski, 502 Park St.  
Mrs. William G. Young, 238 North Oxford

## MANCHESTER

Mrs. Amos E. Friend, 79 Comstock Rd.  
Mrs. Edwin C. Higgins, 118 Porter  
Mrs. Charles E. Jacobson, Jr., 28 Otis  
Mrs. A. A. Willis, 68 Plymouth Lane  
Mrs. E. R. Zaglio, 63 Lakewood Circle

## NEW BRITAIN

Mrs. Louis W. Daley, 49 Lexington  
Mrs. George W. Dunn, 300 Lincoln  
Mrs. Joseph Kalett, 30 Elbridge Rd.  
Mrs. John Larkin, 99 Hart  
Mrs. Joseph T. Matteis, 422 Monroe  
Mrs. Edward Resnick, 13 Vine  
Mrs. Samuel D. Schupack, 38 Macon Dr.  
Mrs. Paul W. Tisher, 389 Shuttle Meadow Ave.  
Mrs. David Waskowitz, 33 Wightman Rd.  
Mrs. John C. White, 115 Vine

## ROCKY HILL

Mrs. F. W. Delligan, 119 Bailey Rd.

## SIMSBURY

Mrs. James E. Stretch, Hopmeadow

## SOUTHINGTON

Mrs. William T. Nagle, 23 Woodruff

## SUFFIELD

Mrs. William H. Upson, 172 Main

## WAREHOUSE POINT

Mrs. Rudolph Maslak, South Main

## WEST HARTFORD

Mrs. Michael A. Corcoran, 64 Arnoldale Rd.  
Mrs. George Crawley, 15 Brookline Dr.  
Mrs. James E. David, 16 Sunny Reach Dr.  
Mrs. Thomas H. Denne, 39 North Main  
Mrs. R. C. Edson, 36 Westfield Rd.  
Mrs. F. S. Ellison, Wood Pond Rd.  
Mrs. Victor L. Farland, 30 Webster Heights Blvd.  
Mrs. Henry Furness, 56 Bainbridge Rd.  
Mrs. John N. Gallivan, 74 Conn. Blvd.



## WOMAN'S AUXILIARY

Mrs. F. D. Gibson, 36 Concord  
 Mrs. Lewis A. Giffin, 27 Arlington Rd.  
 Mrs. Charles W. Goff, 1075 North Main  
 Mrs. George A. Gosselin, 178 North Quaker Lane  
 Mrs. Robert H. Hepburn, 1065 Mountain Rd.  
 Mrs. Arthur C. Heublein, 184 Fern  
 Mrs. J. Grant Irving, 20 Brookline Dr.  
 Mrs. Frank S. Jones, 7 Ten Acre Lane  
 Mrs. Dewey Katz, 140 Fern  
 Mrs. F. Earle Kunkel, 2797 Albany Ave.  
 Mrs. J. Whitfield Larrabee, 54 Walbridge Rd.  
 Mrs. J. R. Lenehan, 716A Farmington Ave.  
 Mrs. Moses D. Lischner, 3 Lawler Rd.  
 Mrs. Milton F. Little, 38 Walbridge Rd.  
 Mrs. Harry Locke, 39 Robin Rd.  
 Mrs. Thomas J. Luby, 14 Bainbridge Rd.  
 Mrs. Francis L. Lundborg, 35 North Main  
 Mrs. Morris M. Mancoll, 285 North Quaker Lane  
 Mrs. Thomas F. Murphy, 12 Concord  
 Mrs. John D. O'Connell, 32 Boswell Rd.  
 Mrs. Ralph T. Ogden, 15 Thicket Lane  
 Mrs. J. G. M. Olmsted, 24 Westwood Rd.  
 Mrs. Stanley H. Osborn, 41 Brace Rd.  
 Mrs. Robert H. Osmond, 29 Cornell Rd.  
 Mrs. Philip F. Parshley, 319 North Quaker Lane  
 Mrs. Winthrop Partridge, 129 Ridgewood Rd.  
 Mrs. A. W. Peacock, 36 Four Mile Rd.  
 Mrs. Maxwell O. Phelps, Sunset Farm  
 Mrs. A. J. Robinson, 34 Stratford Rd.  
 Mrs. Arthur F. Roche, 69 Newport Ave.  
 Mrs. H. B. Rollins, 16 Pelham Rd.  
 Mrs. George J. Rosenbaum, 647 New Britain Ave.  
 Mrs. Ernest Rosenthal, 17 Pine Rd.  
 Mrs. Albert Rubin, 276 Fern  
 Mrs. G. Gardner Russell, 24 Colony Rd.  
 Mrs. Sidney Sewall, 351 Ridgewood Rd.  
 Mrs. George Shaw, 328 Fern  
 Mrs. J. H. Sigal, 16 Thomson Rd.  
 Mrs. C. Leonard Smith, 36 West Beacon  
 Mrs. Wells Standish, 64 Linnard Rd.  
 Mrs. John F. Sweet, Four Mile Rd.  
 Mrs. Robert Tennant, 118 Whitman Ave.  
 Mrs. Carl L. Thenebe, 4 Walbridge Rd.  
 Mrs. Hartwell G. Thompson, 184 Mountain Rd.  
 Mrs. Ralph M. Tovell, 1897 Asylum Ave.  
 Mrs. Charles Tucker, 179 Sidney  
 Mrs. Ewen VanKleeck, 53 Concord  
 Mrs. Carl L. Vernlund, Sunset Farm  
 Mrs. Arthur C. Unsworth, 47 Concord  
 Mrs. Charles K. Wallace, 34 Sunset Ter.  
 Mrs. Loftus Walton, 103 Walbridge Rd.  
 Mrs. Julius Weiner, 119 Trout Brook Dr.  
 Mrs. Stanley B. Weld, 136 Steele Rd.  
 Mrs. Orin R. Witter, 7 Ledyard Rd.  
 Mrs. Thatcher W. Worthen, 183 Bloomfield Ave.  
 Mrs. George Wulp, 52 North Quaker Lane  
 Mrs. R. M. Yergason, 89 VanBuren Ave.  
 Mrs. Michael Zeman, 165 North Quaker Lane

## WETHERSFIELD

Mrs. Henry Stempa, 504 Wolcott Hill Rd.

## WINDSOR

Mrs. Harvey B. Goddard, E. Windsor Hill

## Litchfield County

## CANAAH

Mrs. Forbes S. Adam  
 Mrs. John Elliott

## CORNWALL

Mrs. W. Bradford Walker

## LITCHFIELD

Mrs. A. W. Dautrich  
 Mrs. John F. Kilgus  
 Mrs. C. N. Warner, Jr.

## NEW HARTFORD

Mrs. Heinz W. Markwald

## NORFOLK

Mrs. Richard Barstow, The Village Green  
 Mrs. Frank Ursone, Greenwood Rd.

## SHARON

Mrs. Jerome S. Chaffee  
 Mrs. G. S. Gudernatch

## THOMASTON

Mrs. Henry Atha, 147 Elm  
 Mrs. C. T. Conklin  
 Mrs. Robert Hazen, 45 Union  
 Mrs. Winfield E. Wight, 24 Goodwin Court

## TORRINGTON

Mrs. Sidney A. Chait, Clearview Ave.  
 Mrs. Thomas J. Danaher, 445 Prospect  
 Mrs. Louis E. Garston, 116 Irving Ave.  
 Mrs. Michael Giobbe, 102 Pearl  
 Mrs. Isadore S. Goldberg, 101 Adelaide Ter.  
 Mrs. Harry B. Hanchett, Town Farm Rd.  
 Mrs. Emerson Hill, West View Ter.  
 Mrs. Gilbert Hubert, 35 Blake  
 Mrs. J. Henry Kott  
 Mrs. Domenico LoRusso, 127 Blake  
 Mrs. William Murcko, 28 Wheeler Lane  
 Mrs. Herbert Oelschlegel, 94 Albert  
 Mrs. Andrew Orłowski, 64 Bellevue Ave.  
 Mrs. Frank Polito, 636 East Main  
 Mrs. Nicholas Samponaro, 231 Calhoun  
 Mrs. T. L. Thomson, 59 Forest  
 Mrs. Gert Wallach, 91 Church  
 Mrs. Floyd A. Weed

## WASHINGTON

Mrs. Frederick W. Wersebe

## WATERTOWN

Mrs. Joseph O. Collins, Box 693  
 Mrs. Lawrence Koleshko, 493 Watertown Ave.

Mrs. Royal A. Meyers, 162 Main  
 Mrs. Chris Neuswanger, 64 Hillcrest  
 Mrs. Frank Richenback, 228 Cutler

#### WINSTED

Mrs. Homer C. Ashley, 120 Williams Ave.  
 Mrs. Chester English, 88 Wheeler  
 Mrs. S. Paul Funkhouser, 26 Elm  
 Mrs. Francis J. Gallo  
 Mrs. Donald W. Herman, 42 Walnut

#### WOODBURY

Mrs. Arthur Gillette

### Middlesex County

#### CHESTER

Mrs. Eugene F. Callender  
 Mrs. David Lieberman

#### CLINTON

Mrs. Norman Rindge, 20 Commerce

#### CROMWELL

Mrs. Richard F. Grant, 145 Main  
 Mrs. William Joyce, 92 Main  
 Mrs. Walter N. Nelson, 76 Main

#### DEEP RIVER

Mrs. Russell Lobb, Main  
 Mrs. William J. Tate

#### DURHAM

Mrs. Henry Sherwood, Main

#### EAST HAMPTON

Mrs. Norman H. Gardner, 22 Summit  
 Mrs. Louis Soreff, 15 Main

#### ESSEX

Mrs. William Ames  
 Mrs. Frederick Bradeen, Box 221  
 Mrs. James C. Scott

#### HIGGANUM

Mrs. Norah Burr, Depot Hill Rd.  
 Mrs. Hazen Calhoun  
 Mrs. G. Mansfield Craig

#### MIDDLETOWN

Mrs. Willard Buckley, 23 Mazzotta Pl.  
 Mrs. Carl C. Chase, 134 Clover  
 Mrs. Charles B. Chedel, 148 Broad  
 Mrs. Clair B. Crampton, 158 Mt. Vernon  
 Mrs. Harry S. Frank, 230 Washington  
 Mrs. Norman Gissler, Nathan Hale Rd.  
 Mrs. Julius Grower, 32 Mansfield Ter.  
 Mrs. Carl C. Harvey, 20 Silver  
 Mrs. Harry C. Knight, 35 Crescent  
 Mrs. Louis Loffredo, 77 Crescent  
 Mrs. Joseph Magnano, 100 Broad

Mrs. Lloyd Minor, 495 Ridge Rd.  
 Mrs. Mario Palmieri, 54 Broad  
 Mrs. Peter F. Piasta, 145 South Main  
 Mrs. John Pilecki, 468 Main  
 Mrs. Abraham Raffkind, 217 South Main  
 Mrs. Benjamin Roccapiore, 287 Washington Ter.  
 Mrs. Charles Russman, Conn. State Hospital  
 Mrs. Dale Scholz, 30 Silver  
 Mrs. Benjamin Simon, Conn. State Hospital  
 Mrs. Harold Speight, 29 Saybrook Rd.  
 Mrs. Charles S. Sutch, Conn. State Hospital  
 Mrs. Alfred N. Sweet, 720 Ridge Rd.  
 Mrs. Mark Thumim, 57 South Main  
 Mrs. F. Erwin Tracy, Old Mill Rd.  
 Mrs. Vincent J. Vinci, 70 Crescent  
 Mrs. Harry Whiting, Conn. State Hospital  
 Mrs. Willaim Wrang, 8 Mazzotta Pl.  
 Mrs. Edgar C. Yerbury, Conn. State Hospital

#### MOODUS

Mrs. Phillip Berwick, Box 268  
 Mrs. Thomas E. Horsefield

#### OLD SAYBROOK

Mrs. Aaron Greenberg, Main  
 Mrs. Robert Saunders

#### PORTLAND

Mrs. Stanley Alexander, 229 Main  
 Mrs. Hamilton Rinde, 230 Main  
 Mrs. Philip Schwartz, 309 Main  
 Mrs. Carl Wagner, 38 Bartlett

### New Haven County

#### ANSONIA

Mrs. John Renehan, 67 North Cliff

#### BRANFORD

Mrs. William J. Bodie  
 Mrs. Michael J. Carpinella, 48 Kirkham  
 Mrs. Charles Gaylord, 93 South Main  
 Mrs. Nathan Levy, 140 Montowese  
 Mrs. Arthur S. McQueen, 187 Montowese

#### CHESHIRE

Mrs. Edward Herr, Main  
 Mrs. Wilbur Moore

#### DERBY

Mrs. Edward Blumenthal, 170 New Haven Ave.  
 Mrs. George Burns, 42 Seymour Ave.  
 Mrs. Charles M. D'Alessio, 26 Atwater Ave.  
 Mrs. Dominic D'Ambruoso, 46 Atwater Ave.  
 Mrs. Samuel M. Dreher, 34 Lewis  
 Mrs. Ralph Edson, 77 Oak Ave.  
 Mrs. Samuel Rentsch, 61 Seymour Ave.

#### DEVON

Mrs. Oliver B. Andrus, 531 Daytona Ave.



## HAMDEN

Mrs. Alexander Bassin, Millbrook  
 Mrs. John Brody, 34 Belmont  
 Mrs. John H. Bumstead, 82 Blake Rd.  
 Mrs. Louis N. Claiborn, 64 Blake Rd.  
 Mrs. Arthur Connolly, 175 Tokeneke Dr.  
 Mrs. Walter V. Corey, 1188 Whitney Ave.  
 Mrs. Charles Culotta, 99 Glenbrook Ave.  
 Mrs. Clyde Deming, 2 Marshall Rd.  
 Mrs. Malcolm S. Eveleth, 21 Middle Rd.  
 Mrs. Lewis Foster, 88 Blake Rd.  
 Mrs. James Fox, 140 Davis St.  
 Mrs. Benedict Harris, 51 Caroline  
 Mrs. Maurice Hillman, 39 Helen  
 Mrs. Carl Johnson, 45 Kildeer Rd.  
 Mrs. Simon Kleiner, 80 Tokeneke Dr.  
 Mrs. Marvin Latimer, 1030 Whitney Ave.  
 Mrs. Herman C. Little, 171 Santa Fe Ave.  
 Mrs. James McKeon, 1828 Dixwell Ave.  
 Mrs. Arthur Morse, 141 Deepwood Dr.  
 Mrs. William O'Brien, 32 Hall  
 Mrs. Harlan Perrins, 129 Davis  
 Mrs. G. F. Powers, 167 Armory  
 Mrs. Everett S. Rademacher, 449 Ridge Rd.  
 Mrs. Frederick Roberts, 107 Middle Rd.  
 Mrs. William Ryder, 3 Middle Rd.  
 Mrs. Robert F. Scholl, 30 Swarthmore  
 Mrs. S. J. Silverberg, 140 Laurel Rd.  
 Mrs. Emerson L. Stone, 3 Bayberry Rd.  
 Mrs. Charles Verstandig, 19 Filbert

## MERIDEN

Mrs. Stanley Boguniecki, 114 East Main  
 Mrs. Henry Caplan, 219 West Main  
 Mrs. Max Caplan, Hayes  
 Mrs. William C. Carey, 136 Eaton Ave.  
 Mrs. David Cohen, 229 Sherman Ave.  
 Mrs. Michael Conroy, 57 William Ave.  
 Mrs. S. F. DeRosa, 29 Cook Ave.  
 Mrs. George Fox, 168 Carpenter Ave.  
 Mrs. Cole B. Gibson, Undercliff  
 Mrs. James Giddings, 766 Broad  
 Mrs. W. E. Hall, 5 Washington Heights  
 Mrs. Henry Krochmal, 97 Lincoln  
 Mrs. Jermone L'Heureux, 104 Wilcox Ave.  
 Mrs. Stephen Lirot, 17 Windsor Ave.  
 Mrs. Walter Lohrmann, Undercliff  
 Mrs. Joseph McKrut, 569 East Main  
 Mrs. Bernard Mills, 94 East Main  
 Mrs. Joseph Misuk, 16 Collins Parkway  
 Mrs. Thomas Murdock, 19 Windsor Ave.  
 Mrs. Fessenden N. Otis, 115 Winthrop Ter.  
 Mrs. Israel Otis, 40 Howard Ave.  
 Mrs. Harry Pennington, 119 Williams  
 Mrs. Rocco J. Petrucelli, 155 Main  
 Mrs. Louis Pierson, 130 Bradley Ave.  
 Mrs. Raymond Quinlan, 36 Winthrop Ter.  
 Mrs. Edward R. Smith, Coe Ave.  
 Mrs. Harold Strickland, 128 Main  
 Mrs. L. E. Thompson, Undercliff  
 Mrs. James VanLeuvan, 62 Hill Crest Ter.  
 Mrs. J. Alfred Wilson, 128 Curtis

## MIDDLEBURY

Mrs. John Foster, Porter Hill  
 Mrs. A. A. Johnson, Crest Rd.

## MILFORD

Mrs. Walter E. Barney, 186 Broad

## NAUGATUCK

Mrs. D. H. Bluestone, 9 Terrace Ave.  
 Mrs. William E. Hill, 150 Meadow  
 Mrs. Walter Riley, 170 Meadow  
 Mrs. Leo Tyles, 156 Meadow

## NEW HAVEN

Mrs. Edward P. Allen, 147 Alden Ave.  
 Mrs. Millard F. Allen, 65 Dixwell Ave.  
 Mrs. Creighton Barker, 119 Armory  
 Mrs. Charles J. Bartlett, 183 Bishop  
 Mrs. A. W. Battista, 111 Osborn Ave.  
 Mrs. Edmund J. Behan, 2015 Chapel  
 Mrs. Benedict Biondi, 120 Blatchley Ave.  
 Mrs. Francis G. Blake, 311 St. Ronan  
 Mrs. Joseph Bruno, 505 Whalley Ave.  
 Mrs. Alfonso Capecelatro, 142 Columbus Ave.  
 Mrs. William F. Collins, 181 Howard Ave.  
 Mrs. Mario Conte, 774 Townsend Ave.  
 Mrs. Robert Jay Cook, 651 Prospect  
 Mrs. A. Nowell Creadick, 77 Loomis Pl.  
 Mrs. Joseph D'Amico, 25 Lyon  
 Mrs. Arthur Dayton, 61 Loomis Pl.  
 Mrs. William J. Dennehy, 600 Prospect  
 Mrs. Joseph D'Esopo, 501 Whitney Ave.  
 Mrs. Frank DiStasio, 251 Edwards  
 Mrs. Simon Doff, 362 Yale Ave.  
 Mrs. Joseph E. Evans, 1488 Chapel  
 Mrs. Joseph Fiorito, 157 Cleveland Rd.  
 Mrs. Peter Fiskio, 307 Humphrey  
 Mrs. Harold Flynn, 464 Dixwell Ave.  
 Mrs. Barnett Freedman, 322 George  
 Mrs. Angelo Gentile, 155 Upson Ter.  
 Mrs. James Gettings, 256 McKinley Ave.  
 Mrs. Reginald Gillson, 618 Whitney Ave.  
 Mrs. Roy J. Gilmer, 256 Dixwell Ave.  
 Mrs. Samuel Goldberg, Sr., 508 Yale Ave.  
 Mrs. Morris Goldstein, 451 George  
 Mrs. Barnett Greenhouse, 1687 Boulevard  
 Mrs. Joseph Groark, 856 Townsend Ave.  
 Mrs. Francis Guida, 67 Trumbull  
 Mrs. Morris A. Hankin, 1620 Boulevard  
 Mrs. James C. Hart, 820 Elm  
 Mrs. Samuel Harvey, 211 Highland  
 Mrs. Clayton Hitchins, 1567 Chapel  
 Mrs. Charles H. Hodgkins, Jr., 831 Elm  
 Mrs. Samuel D. Kushlan, 655 Whitney Ave.  
 Mrs. Maxwell Lear, 441 Ellsworth Ave.  
 Mrs. Hyman Levin, 168 Linden  
 Mrs. Robert Lewis, 52 Trumbull  
 Mrs. Gustaf Lindskog, 50 Marvel Rd.  
 Mrs. William Logan, 2000 Chapel  
 Mrs. Robert Lowman, 108 Livingston  
 Mrs. Carter Marshall, 215 Lakeview Ter.  
 Mrs. Harry C. Maynard, 882 Howard Ave.

Mrs. William C. McGuire, 925 Forest Rd.  
 Mrs. William Mendelsohn, 170 Linden  
 Mrs. Frank Mongillo, 20 Elmwood Rd.  
 Mrs. Donald Moore, 588 Howard Ave.  
 Mrs. Kenneth R. Morgan, 168 Prospect  
 Mrs. Harry G. Moss, 646 Dixwell Ave.  
 Mrs. Luther Musselman, 192 Livingston  
 Mrs. Joseph Newman, 150 Shelton Ave.  
 Mrs. Ralph Nichols, 62 West Rock Ave.  
 Mrs. Louis O'Brasky, 530 Ellsworth Ave.  
 Mrs. Denis O'Connor, 394 Central Ave.  
 Mrs. John Peters, 123 Marvel Rd.  
 Mrs. Joseph Petrelli, 157 East Rock Rd.  
 Mrs. Samuel Phillipson, 665 Ellsworth Ave.  
 Mrs. David Poverman, 67 Trumbull  
 Mrs. Walter S. Russell, 139 Alston Ave.  
 Mrs. Marvin M. Scarbrough, 47 Trumbull  
 Mrs. R. B. Seabury, 58 Trumbull  
 Mrs. Michael S. Shea, 500 Howard Ave.  
 Mrs. Morris R. Slater, 68 Norton  
 Mrs. Frederick Sperry, 217 St. Ronan  
 Mrs. William Stetson, 646 Dixwell Ave.  
 Mrs. Harry Stewart, 35 Pendleton  
 Mrs. Maurice Strauss, 18 Everit  
 Mrs. Herbert Thoms, 272 Edgehill Rd.  
 Mrs. Wilder Tileston, 15 Edgehill Rd.  
 Mrs. Frank E. Toole, 413 Whalley Ave.  
 Mrs. Michael Vegliante, 174 Bradley  
 Mrs. Edward Wakeman, 181 Edwards  
 Mrs. Arthur Weil, 670 Prospect  
 Mrs. Sidney Winters, 170 McKinley Ave.

#### NORTHFORD

Mrs. R. E. McDonnell

#### NORTH HAVEN

Mrs. Eugene Blake  
 Mrs. Orvan Hess, Old Orchard Rd.  
 Mrs. Irving G. Shaffer, Skiff

#### ORANGE

Mrs. Melchior Savarese, Box 260, Derby Ave.

#### SEYMOUR

Mrs. William Harrison, Great Hill Rd.  
 Mrs. Oscar Rogol, 128 North

#### WALLINGFORD

Mrs. John C. Carrozzella, 35 South Main  
 Mrs. William Morriss, Gaylord Farms  
 Mrs. Siegard Pelz, 26 South Main  
 Mrs. Mark T. Sheehan, 245 Center

#### WATERBURY

Mrs. H. Everett Allen, 210 Woodlawn Ter.  
 Mrs. Charles H. Audet, 42 Church  
 Mrs. Walter L. Barber, Jr., 102 Euclid Ave.  
 Mrs. Theodore F. Bevans, 165 Fiske  
 Mrs. Orpheus J. Bizzozero, Country Club Rd.  
 Mrs. Rudolf Blau, 47 Cooke  
 Mrs. Maxwell H. Bloomberg, 197 Lincoln  
 Mrs. Clarence H. Cole, 119 Coniston Ave.

Mrs. Alfred Dreher, 292 Gaylord Dr.  
 Mrs. Edward Godfrey, 633 Willow  
 Mrs. Jacques Green, 192 Euclid Ave.  
 Mrs. Albert E. Herrmann, 142 Robinwood Rd.  
 Mrs. Joseph L. Hetzel, 81 Euclid Ave.  
 Mrs. Milton Jennes, 91 Prospect  
 Mrs. Sidney K. Jennes, 107 Farmington Ave.  
 Mrs. Edward Kirschbaum, Eastfield Rd.  
 Mrs. Frederick LaBrecque, 132 Columbia Blvd.  
 Mrs. William J. Lenkowski, 38 Euclid Ave.  
 Mrs. Edward Lewicki, Montoe Rd.  
 Mrs. Elliott Mayo, 129 Prospect  
 Mrs. Harold Morrill, 300 West Main  
 Mrs. Robert Pollard, 76 Euclid Ave.  
 Mrs. J. Harold Root, 22 Fleming  
 Mrs. Vincent Shea, 90 Tower Rd.  
 Mrs. Joseph Slavin, 798 East Main  
 Mrs. Arthur Sullivan, 185 Baldwin Ave.

#### WEST HAVEN

Mrs. Harold S. Appell, 354 Campbell Ave.  
 Mrs. Carl Giannotti, 399 Savin Ave.  
 Mrs. Frederick Kessler, 233 Elm  
 Mrs. William O'Connell, 295 Main  
 Mrs. Platt Rogers, 228 Elm

#### WOODBIDGE

Mrs. Bruno H. Arnold, Beecher Rd.  
 Mrs. William Perham, Newton Rd.  
 Mrs. Paul Vestal, Amity Rd.  
 Mrs. Arthur Yudkin, Tallwood Rd.

#### WOODMONT

Mrs. Alexander B. Timm, Jr., 139 Morningside Dr.

### New London County

#### COLCHESTER

Mrs. Irving Friedman, 6 Norwich Ave.  
 Mrs. H. P. Schwarz, 7 Broadway

#### GROTON

Mrs. E. L. Douglas, 198 Thames  
 Mrs. Erich Goldmeier, 303 Thames  
 Mrs. C. T. Hewes, 185 Thames

#### LYME

Mrs. Julian Ely, R. F. D. No. 2

#### MYSTIC

Mrs. B. B. Crandall, 31 Grand  
 Mrs. Roger Fowler, 5 Liberty  
 Mrs. E. R. Hill, 43 East Main  
 Mrs. Thurman Maine, 64 Washington

#### NEW LONDON

Mrs. Eric Blank, 36 Shirley Lane  
 Mrs. John F. Brosnan, 223 Glenwood Ave.  
 Mrs. George Cheney, 179 Montauk Ave.  
 Mrs. Louis DeAngelis, 252 Montauk Ave.



Mrs. F. M. Dunn, 26 Broad  
 Mrs. Frederick Hartman, 219 Glenwood Ave.  
 Mrs. L. Hendel, 336 Pequot Ave.  
 Mrs. E. A. Henkle, 51 Federal  
 Mrs. Robert P. Henkle, 51 Federal  
 Mrs. Harold Irwin, 55 Linden  
 Mrs. C. Kaufman, 16 Jermone Ct.  
 Mrs. Hugh Lena, 154 Broad  
 Mrs. Tage Neilson, 195 Williams  
 Mrs. Duncan MacDougal, Ocean Ave.  
 Mrs. Willard Morse, 32 Channing  
 Mrs. Thomas Murray, 32 Huntington  
 Mrs. Albert C. Rapp, 261 Gardner Ave.  
 Mrs. Phillip Savage, 203 Ledyard  
 Mrs. Victor Smilgin, 265 Williams  
 Mrs. James Sturtevant, 223 Ledyard  
 Mrs. Morris Sulman, 14 Greenway Rd.  
 Mrs. Robert Taylor, Quaker Hill  
 Mrs. Hill Warren, 164 Hempstead  
 Mrs. Carl Weiss, 756 Pequot Ave.  
 Mrs. H. W. Wellington, 2 Worthington Rd.  
 Mrs. Frank E. Wilson, 127 Glenwood Ave.  
 Mrs. Joseph Woodward, 40 Guthrie Pl.

## NIANTIC

Mrs. Lawrence S. Ward, Main

## NORWICH

Mrs. Mario Albamonti, 46 Rockwell  
 Mrs. H. A. Bergendahl, 167 Harland Rd.  
 Mrs. C. E. Bielecki, 40 Harland Pl.  
 Mrs. Hugh Campbell, 275 Broadway  
 Mrs. Sidney Drobnes, Harland Rd.  
 Mrs. M. A. Ferrara, Uncas-on-Thames  
 Mrs. G. H. Gildersleeve, 100 Harland Rd.  
 Mrs. H. W. Higgins, 3 Sachem Ter.  
 Mrs. Winfield Kelly, Uncas-on-Thames  
 Mrs. Maurice Moore, Laurel Hill Rd.  
 Mrs. Kurt Oppenheimer, 5 Julian  
 Mrs. Lincoln Oppen, State Hospital  
 Mrs. Anthony Pepe, State Hospital  
 Mrs. Albert Quintilliani, 35 Williams  
 Mrs. Solam Segel, 219 Broadway  
 Mrs. John Suplicki, 40 Slater Ave.  
 Mrs. Clarence Thompson, 181 Broadway  
 Mrs. William B. Wener, 22 Harland Pl.

## OLD LYME

Mrs. E. K. Devitt

## STONINGTON

Mrs. Henry Haines, Pequot Trail  
 Mrs. Willard Veal, 99 Water

## TAFTVILLE

Mrs. H. A. Archambault, 2 North Second Ave.

## WATERFORD

Mrs. Walter Lukoski, Seaside Sanatorium  
 Mrs. J. P. O'Brien, Seaside Sanatorium  
 Mrs. Richard Starr, Best View  
 Mrs. S. P. Tombari, Seaside Sanatorium

## Windham County

## DANIELSON

Mrs. Cecil Garcin  
 Mrs. Andrew Laakso, 213 North Main  
 Mrs. Warren Tanner, 36 Academy

## HAMPTON

Mrs. A. D. Marsh

## MANSFIELD

Mrs. Neil Dayton, Mansfield State Training School

## MANSFIELD CENTER

Mrs. Kenneth Kinney

## MOOSUP

Mrs. John A. Woodworth

## PLAINFIELD

Mrs. Arthur A. Chase  
 Mrs. Angelo Gulino

## PUTNAM

Mrs. Karl T. Phillips, 36 Church  
 Mrs. William Mac Shepard  
 Mrs. John Russell, Main

## STORRS

Mrs. Ralph L. Gilman, Willowbrook Rd.

## THOMPSON

Mrs. Robert Paine

## WILLIMANTIC

Mrs. Conrad Baker  
 Mrs. George H. Carter, 158 Chestnut  
 Mrs. Gerard Chartier, 148 Chestnut  
 Mrs. J. A. Girouard, 250 Pleasant  
 Mrs. Reuben Rothblatt, 25 Whiting  
 Mrs. N. Spector

## WINDHAM CENTER

Mrs. Morton Arnold

## WINDHAM

Mrs. Edward Ottenheimer

## WOODSTOCK

Mrs. David Bates

## OBITUARIES

### Clinton J. Hyde, M.D.

1880 - 1946

Clinton J. Hyde, a former chief of the medical staff of the Milford Hospital Society, died at the Grace Hospital, New Haven, Connecticut, on June 25, 1946. He was born in Brooklyn, Connecticut, on September 25, 1880, the son of Henrietta Ennis Hyde, formerly of Westerly, Rhode Island, and Irvin John Hyde, formerly of Southington, Connecticut.

Dr. Hyde received his early education in the Willimantic public schools and was graduated from New York University and the Bellevue Hospital Medical College in 1903. After internship at the Bellevue Hospital, Dr. Hyde practiced general medicine in Brooklyn and in Hartford and also served in a medical capacity for five years at the Hudson River State Hospital in Poughkeepsie, New York. He came to Milford in 1918 and practiced general medicine here until his last illness.

Dr. Hyde was a member of the Connecticut State Medical Society, the New Haven County Medical Association, the B.P.O. Elks and the Redmen. He was vice-president of the Milford Hospital Society as well as a member of the Board of Directors, and also a member of the medical staff of that institution at the time of his death.

Surviving are his wife, Josephine A. M. Hyde, and son, John, of Milford; also a son, David C. of Binghamton, New York, and a daughter by a former marriage, Mrs. Bernice Hendersón of Nichols, Connecticut.

In spite of failing health, Dr. Hyde remained active in the medical profession and served untiringly and to the best of his ability until but a short time before his death. His friends as well as the doctors with whom he was associated realize that his untimely death brings to a close a useful and busy life. His passing leaves a gap in the community which he has served for so long.

W. J. H. Fischer, M.D.

### John Joseph Thomas, M.D.

1896 - 1946

John Joseph Thomas was born in Ansonia on December 27, 1896, the son of John and Mary Thomas. He died on October 14, 1946.

Dr. Thomas was a graduate of Ansonia High School in the class of 1915. He took his premedical work at New York University and completed his medical studies at Fordham University with the class of 1921. He served in the United States Army as a private in World War I and then interned at St. Catherine Hospital in Brooklyn, New York, for two years.

Dr. Thomas was medical examiner for the Metropolitan Life Insurance Company for 25 years and was industrial surgeon with the Ansonia branch of Farrel Birmingham Co. for almost ten years. He was a member of the surgical staff of the Griffin Hospital in Derby, and was a member and a Past Exalted Ruler of the Ansonia Lodge of Elks.

In 1925 he was married to Eileen Rutledge Barry of Guelph, Ontario, Canada, in New York City. Mrs. Thomas was graduated from St. Catherine Training School for Nurses in Brooklyn, New York.

He leaves besides his wife one son, John Barry Thomas, a premedical student in his junior year at Yale University.

Dr. Thomas died in his 49th year of coronary occlusion at the Griffin Hospital, Derby.

Samuel B. Rentsch, M.D.

### Walter Sidders Lay, M.D.

1870 - 1946

Walter Sidders Lay, son of Richard and Emily Lay, was born in Saybrook, Connecticut, in 1870 and died December 10, 1946 in Hamden at the age of 76 from arteriosclerosis and cerebral hemorrhage. He was married to Mabel Beatty of Sandusky, Ohio who survives him.



Dr. Lay received his early education in local schools in the neighborhood of Saybrook and under private tutors, entering the Yale Medical School where he graduated in 1901 with high honors, receiving a cum laude and the Campbell gold medal. Following his graduation from Yale he interned at the Middletown Hospital for the Insane and at the Backus Hospital in Norwich, Connecticut, and was for a time thereafter connected with the staff of the Middletown Hospital. In 1903 he opened an office in Hamden where he developed a large general practice which continued until ill health forced his gradual retirement which began about two years before his death.

Dr. Lay was a high type of physician and never spared himself where the interests of his patients, community or nation were involved. His patients were always his loyal friends and he took an active interest in Hamden community affairs, serving as town health officer from 1904 to 1915, and again from 1938 to 1946. He was at one time a member of the Governor's Foot Guard, and served as major in the first World War, commanding the 361st Field Hospital Company, 316th Sanitary Train, 91st Division. This unit went through the battles at St. Mihiel, the Argonne, Meuse offensive and the Lys Scheldt River offensive, and he was officially commended for his efficiency.

Following the first World War he continued his military activities, serving in the Officers Reserve Corps and being made Commanding Officer of the 301st Medical Regiment, 76th Division. In 1925 he was promoted to Lieutenant Colonel and to Colonel in 1926, being retired in 1934. He instituted and personally edited annually for twenty-five years a Christmas bulletin giving news of all the officers and men who had served under him in the first World War.

Dr. Lay was a strong supporter of the Hamden Branch of the Red Cross and was a member of the Civil Defense Committee, organizing and equipping emergency stations during the last war. He was also a member of the Selective Service Board of Appeal of New Haven.

Dr. Lay's many professional, civic and military activities left him but little time for hobbies, but he was interested in fishing, was a Mason for fifty-four years and a charter member of the Hamden Rotary Club.

His outstanding characteristics were kindness, conscientiousness and public service. One of the men who served under him during the first World War has written: "He was the kindest hearted, most considerate and beloved man in the whole U. S. Army."

Dr. Lay's community, patients and friends have lost a doctor of the highest type.

Thomas H. Russell, M.D.

### Gabriel Joseph Jack, M.D.

1885 - 1947

Gabriel J. Jack died suddenly on February 6, 1947. He had been well aware of his infirmities for a long time. The sword of Damocles had no terrors for this intrepid spirit. His keen interest in all matters was never dimmed. He listened patiently and courteously to his numerous patients, many of whom had complaints trivial compared to his.

"Gay" Jack was born in 1885 and was graduated from Boston University in 1907. He interned at Grace Hospital and always was closely identified with that institution. Like Ian Maclaren's famous character, he was "a doctor of the old school" and also like MacLure (of Drumtochty) he combined science with art and kindness. Seldom do we encounter a man so well beloved by all of his patients. He knew them as human beings. He not only prescribed for them and operated on them, but he brought many of them food and supplies. I am convinced that he derived the greatest of satisfaction and happiness from this. He found the time week in and week out, year after year, to do the enormous shopping which this program entailed. This, and his gardening, were his greatest avocations.

His funeral services were held partly in New Haven where his Masonic brethren officiated, and partly in the Episcopal Church at Cheshire, Connecticut. He was placed in the little cemetery on the hill above the church beside his wife who had preceded him there by many years.

Daniel F. Levy, M.D.

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### New A.M.A. Appointment

Dr. Lawrence Kerr Rainsford of New York joined the staff of the Council on Medical Education and Hospitals as hospital inspector about July 1.

## SPECIAL NOTICES

### THE AMERICAN CONGRESS OF PHYSICAL MEDICINE

Will hold its twenty-fifth annual scientific and clinical session September 2, 3, 4, 5 and 6 inclusive, at the Hotel Radisson, Minneapolis. Scientific and clinical sessions will be given the days of September 3, 4, 5 and 6. All sessions will be open to members of the medical profession in good standing with the American Medical Association. In addition to the scientific sessions, the annual instruction courses will be held September 2, 3, 4 and 5. These courses will be open to physicians and the therapists registered with the American Registry of Physical Therapy Technicians. For information concerning the convention and the instruction course, address the American Congress of Physical Medicine, 30 North Michigan Avenue, Chicago 2, Illinois.

### AMERICAN COLLEGE OF SURGEONS TO HOLD CLINICAL CONGRESS IN NEW YORK SEPTEMBER 8-12

The thirty-third annual Clinical Congress of the American College of Surgeons, including the twenty-sixth annual Hospital Standardization Conference, will be held at The Waldorf-Astoria, New York, from September 8 to 12. The five day program features operative and nonoperative clinics in 38 hospitals in New York and Brooklyn, and scientific sessions in general surgery and the surgical specialties, official meetings, hospital conferences, medical motion pictures, and educational and technical exhibits, at the headquarters hotel.

### INTERNATIONAL COLLEGE OF SURGEONS ASSEMBLY

The International College of Surgeons, United States Chapter, will hold its Twelfth Annual Assembly and Convocation in Chicago, September 28 to October 4, 1947.

The program will include operative and non-operative clinics, demonstrations, symposia, forums, medical motion pictures, exhibits and the formal dedication of the new library and permanent home of the United States Chapter. All meetings, with the exception of the operative clinics, will be held in the Palmer House and the Stevens Hotel.

The Cook County Hospital of Chicago has reserved Friday, October 3 for operative clinics, round table discussions and demonstrations for the attending Fellows of the College. Twenty other hospitals of Chicago will be hosts at surgical clinics and demonstrations on October 4.

General Chairman of the meeting is Raymond W. Nealy, M.D., Chicago; and Co-chairmen are Karl Meyer, M.D., and Max Thorek, M.D., of Chicago.

Louis J. Garipey, M.D., of Detroit, secretary of the U.S. Chapter, announced that the annual meeting of the House of Delegates and election of officers would be held on September 28 and 29 immediately preceding the Assembly and Convocation. Presiding will be President Herbert Acuff, M.D., of Knoxville, Tennessee.

Copy of the program and detailed information may be obtained by writing Max Thorek, M.D., Co-chairman, 1516 Lake Shore Drive, Chicago, Illinois.

### SECOND ANNUAL POSTGRADUATE COURSE IN DISEASES OF THE CHEST

The American College of Chest Physicians is sponsoring a second annual postgraduate course in diseases of the chest to be held during the week of September 15-20, 1947, at the Municipal Tuberculosis Sanitarium, Chicago, Illinois.

The emphasis in this course will be placed on the newer developments in all aspects of diagnosis and treatment of diseases of the chest.

The course will be limited to 30 physicians. Tuition fee is \$50.00.

Further information may be secured at the office of the American College of Chest Physicians, 500 North Dearborn Street, Chicago 10, Illinois.

### NEW ENGLAND POSTGRADUATE ASSEMBLY

The New England Postgraduate Assembly will be held on Wednesday, Thursday, and Friday, October 29, 30, and 31, at the Copley Plaza Hotel, Boston.



## OUR NEIGHBORS

### Maine

The Maine Medical Association sustained a double defeat in the recent session of the State Legislature. The bill to establish a medical school as a part of the University of Maine was defeated, apparently because of the necessity for an initial appropriation of \$1,000,000. Funds were not available and the Legislature did not see fit to pass either a sales tax or a State income tax or a combination of the two. A bill was substituted to create a commission to study the project of a new medical school during the next two years. This commission is to be composed of three representatives of the University of Maine, three physicians from the Maine Medical Association, and three civilians. The chairman of the Association's special committee feels hopeful of securing a new medical school "if and when money is available."

The other defeat came when the Senate voted down the bill to create an enabling act which would make it possible to set up a voluntary prepaid plan for medical care in Maine. This would have enabled physicians to form a corporation for the purpose of offering this type of insurance to the public. The other groups such as the osteopaths, naturopaths and chiropractors, being excluded, opposed this plan and insisted that the present enabling legislation now granted to Associated Hospital Service was sufficient. Under the present enabling act voluntary prepaid medical care is permitted but requires inclusion of all cultists.

The new president of the Maine Medical Association is Stephen A. Cobb of Sanford, veteran of both World Wars. Forrest B. Ames of Bangor is the new president-elect.

### Massachusetts

At the annual meeting of the Council of the Massachusetts Medical Society held in Boston in May it was voted that the Society in arranging for medical care of veterans in Massachusetts, deal directly with the Veterans Administration under a gentleman's agreement similar to the Kansas Plan. It originally had been planned to cover this program of medical care by a contract between the Blue

Shield and VA but, according to the *New England Journal of Medicine*, this was blocked.

The new officers of the Massachusetts Medical Society for the year 1947-1948 are Edward P. Bagg, president; Daniel B. Reardon, president-elect; Charles J. Kickham, vice-president; Joseph Garland, secretary; Eliot Hubbard, Jr., treasurer; Norman A. Welch, assistant treasurer; Allan S. Johnson, orator.

On July 1 Blue Shield extended its present program of surgical and obstetric benefits to include medical (non surgical) benefits. At the same time a new schedule of fees for services to holders of Blue Shield policies became effective. With nearly 600,000 persons covered Blue Shield is now the second largest and one of the most prosperous medical care plans in the United States. *The New England Journal of Medicine* attributes much of this success to the fact that physician participation, originally in the neighborhood of 50 per cent, has climbed rapidly to its present level of over 90 per cent.

### New York

The Workmen's Compensation Board of New York State has officially announced a partial revision of the Workmen's Compensation Fee Schedule, effective June 1, 1947. First office calls have been increased from \$3 to \$3.50, subsequent office calls, from \$2 to \$2.50. First home visits have been increased from \$4 to \$5 and subsequent house calls from \$3 to \$4. Night calls in the home have been increased from \$5 to \$6 and the time for such moved backward two hours to 10 P. M. Hospital calls have been increased by 50 cents to \$2.50, and hospital night emergency calls from 10 P. M. to 7 A. M. set at \$5. The 5 per cent 30 day discount has been eliminated on bills of \$15 or more.

At the 1947 annual meeting of the Medical Society of the State of New York for the first time the *New York State Journal of Medicine* and the *Directory* featured an exhibit. To entice spectators blue souvenir pencils were given away bearing the reminder "Compliment of the *New York State Journal of Medicine*."

On July 7 Mayor William O'Dwyer formally opened two new rehabilitation wards at Bellevue Hospital, New York City. These two wards will accommodate eighty patients and comprise the first medical rehabilitation program in any civilian general hospital in the United States.

## New York City Acts on Discrimination Against Students

A special committee appointed by the Council of the City of New York to investigate the alleged discrimination against students in secondary schools and colleges in that area has just completed its work. Several organizations and individuals contended "that for the past two decades there had been a gradual diminution in the number of graduates of City colleges admitted to local colleges and other institutions of higher learning, including professional schools." Representatives were examined from Cornell University School of Medicine, College of Physicians and Surgeons of Columbia University, Long Island College of Medicine, New York University School of Medicine, and New York Medical College and Flower Hospital. In their recommendations the committee proposed that the Governor include in his message to the Legislature a request for a State University. It also recommended a provision in all future contracts with schools using City hospitals for instruction of students a provision providing for cancellation upon proof of discrimination in acceptance or rejection of students.

## New Jersey

On June 16 President Schaaf of the Medical Society of New Jersey announced the appointment of James E. Bryan as executive secretary of that society. Mr. Bryan, son of Joseph H. Bryan, M.D., one of Asbury Park's senior practitioners, is well known in medical circles in the east. For twelve years he served as executive officer of the Westchester (N. Y.) Medical Society and since 1944 has been executive secretary of the New York County Medical Society. He was also managing editor of *New York Medicine* and director of public relations of the Coordinating Council of the five medical societies of Greater New York. At Atlantic City in June James E. Bryan was elected secretary-treasurer of the newly organized association of Medical Society Executives.

## Rhode Island

Bristol County physicians have received a charter from the Rhode Island Medical Society permitting them to form a constituent association in that area. This action removes the Bristol delegation from the jurisdiction of the Providence Medical Association.

## Vermont

Sixty per cent of the members of the Vermont State Medical Society have signed participating contracts in New Hampshire-Vermont Physician Service following a campaign for members in April. New Hampshire has a ninety per cent participation.

The Burlington Chamber of Commerce sponsored a National Affairs Conference on July 11 to acquaint citizens with the individual and community relationship to governmental affairs. The Vermont State Medical Society was among the organizations invited to the Conference.

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## NEWS

### *from County Associations*

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## Fairfield

The Bridgeport Board of Health has voted to name a ward in Englewood Hospital the Edwin B. Weldon Pavilion in honor of the late physician. This pavilion will be reserved for convalescent poliomyelitis patients, the cost of whose training and treatment will be provided for by the Fairfield County chapter of the National Foundation for Infantile Paralysis.

Ralph W. Crane, M.D., of Stamford, was recently chosen "the man of the month" by the Stamford Junior Chamber of Commerce. Dr. Crane was selected on the basis of his long service to Stamford and in particular for his work on veterans housing, cited recently by the Federal Housing Association.

James F. Walsh, for over 25 years a practising physician in Bridgeport, died suddenly in Chicago on June 11. Dr. Walsh had gone to Chicago with his wife and one son for a vacation.

## Hartford

Donald B. Cragin, medical director of the Aetna Life Insurance Company since 1933 and former president of the Hartford Board of Health, died at his home in Hartford on July 13. Dr. Cragin was a past president of the Association of Life Insurance Medical Directors and formerly chairman of the medical section of the American Life Convention.



## Litchfield

T. L. Thomson, a practising physician in Torrington for forty-seven years, was presented with a new automobile by residents of that city on his seventieth birthday, June 13.

## Middlesex

June saw a trek of a number of the County physicians to Atlantic City to attend the Centennial of the A.M.A. Among those attending were Philip Berwick, Clare Crampton, Richard Grant, Carl Harvey and his two sons, David and Sanford, Henry Sherwood, Louis Soreff, Julius Grower, Benjamin Rafkind and Erwin Tracy. All reported an excellent convention. Drs. Grower and Sherwood were appointed delegates to the annual meeting of the General Practitioners Section.

On June 26, the Central Medical Association held its annual picnic at Happy Acres. About thirty of the members became (one day) athletes and enjoyed tennis, archery, handball and swimming. The Minor Manglers defeated the Calhoun Cutups in a softball game, the score finally being 7 to 6. The afternoon and evening were sociable occasions, and the committee, under the chairmanship of Mario Palmieri, is to be congratulated. A suggestion was made that we have more of the same.

The Tumor Clinic held at the hospital has doubled its attendance of both patients and attending physicians. It has outgrown its former quarters and now meets in the Auxiliary Gauze Cottage.

Our congratulations to Dr. Stanley Alexander, who has completed his requirements for admission to the American College of Physicians. He makes the third of our colleagues who have attained that distinction.

The Hospital Building Program has reached the stage where plans are being submitted to the General Staff for suggestions and criticisms.

The hospital has negotiated a new contract with the Blue Cross after having been a non member since the tenth of April. Our Board of Directors managed to secure a contract which is more favorable to the hospital.

Mrs. Delena Milardo, who has borne the brunt of the war years as supervisor of the operating room, left this position on July 1 to assume more domestic activities. She was given a farewell party at Dr. Magnano's summer cottage by a number of the sur-

gical staff and surgical nursing personnel. Our best wishes go to her for a happy and tranquil domestic life. Miss Anastacia Chaponis has taken over Mrs. Milardo's duties. Good luck to her.

Philip Schwartz is leaving with his family for an extended automobile tour to California and back. In October, Dr. Schwartz enters Cook County Hospital as a resident in dermatology. He has had a background of fifteen years in general practice which should stand him in good stead in his chosen specialty.

Dr. Joseph Epstein completed his services as resident at the hospital and has opened an office in Middletown. Dr. Frank Hortora completed his service in May and is practicing in New Haven. Dr. Carlton Haines has accepted a residency in surgery in Montpelier. Dr. John Norowski completed his internship and will be opening an office in Danbury in the near future.

Dr. Sanford Harvey, the son of Carl Harvey, began a term as a resident at the hospital on the first of July as did Dr. James Kidney. Dr. Harvey comes to us from Queens County Hospital, New York, and Dr. Kidney from St. Mary's in Waterbury.

Louis LaBella is taking a vacation tour of the Gaspé Peninsula.

Drs. LaBella, McLeod and Vinci have had an article accepted by the *American Journal of Surgery*. This group is getting to be a scientific team.

## New Haven

The following new members were elected to membership in Waterbury Medical Association on June 19: Michael V. Gualtieri, E. J. Whalley, W. H. Caney, Jr., C. T. Conklin, Jr., Jasper A. Smith.

Maurice F. Lindquist, oldest practising physician in New Haven, died in Grace Hospital June 26 at the age of 80. He had been in practice in New Haven for fifty-five years.

Alexander W. Winkler, assistant professor of internal medicine at Yale University School of Medicine, died in New Haven Hospital on June 26. Dr. Winkler was 38 years of age and had been a member of the Yale faculty since 1935.

Three Meriden physicians have been certified recently by specialty boards. Michael J. Conroy and Allan J. Ryan have passed the requirements of the American Board of Surgery and Max Caplan, the American Board of Internal Medicine.

## New London

Edward Clark Streeter, M.D., curator of the museum collections of the Yale Medical Library and former lecturer on medical history at Harvard and Yale Universities, died at his home in Stonington on June 17. Dr. Streeter was a close friend of the late Harvey Cushing and as a collector had joined with Dr. Cushing in giving many of his books as well as his unique collection of weights and measures to the Yale University School of Medicine.

Ralph A. Falcone, graduate of Tufts Medical College 1947, and Frank M. James, graduate of Oklahoma Medical School 1947, are serving as interns at the W. W. Backus Hospital, Norwich.

## Tolland

John E. Flaherty, practising physician in Rockville, has been appointed medical examiner for the towns of Vernon and Tolland, succeeding Thomas F. O'Loughlin, resigned. Dr. Flaherty is also medical examiner for Bolton.

these papers. Of great interest is the follow up report of Dr. René Spitz of his original investigation of children in a foundling home. The unique and overwhelming importance of the mother-child relationship in the first years of life is again exemplified. Of the 91 children originally investigated 2 years before, only 21 were still in the institution. Mental and physical development of these 21 children was extraordinarily retarded, despite the fact that environmental conditions had improved. The deprivation of maternal care, stimulation and love, together with the relative isolation of these infants in the first year of life, seemed to be irreparable. Quite apart from the inadequate psychic and physical development, all these children showed seriously decreased resistance to disease and an appalling mortality. Thirty-four of the original 91 had died. The picture was entirely different in a similar group of institutionalized children for whom a more normal home atmosphere was fostered.

This is an excellent annual with many directives for all workers in the sphere of child psychology and child welfare.

*AGING SUCCESSFULLY.* By George Lawton. New York: Columbia University Press. 1946. 266 pp. \$2.75.

Reviewed by PETER J. STEINROHN

My daughter, just turned four, said to me the other morning, "Daddy, you're *twenty!*" Her inflection identified me without question, as chairman of the board of modern Methuselas. That afternoon a patient of 65 looked at me (age 47) and said with a note of regret in his voice, "Doctor, I wish I were as young as you are."

The reader will agree that, ordinarily, one's point of view regarding Age depends essentially upon 'where you happen to sit'. George Lawton attempts, and I think succeeds, in holding up for our examination many multicolored facets and clear cut prisms of the study known as Gerontology. As a result, we come away with the larger point of view.

In his preface, the author writes that his book is a book for everyone—for the young, the middleaged and the old. Human nature being what it is, one may take exception to the wide sweep of his potential audience.

Further on he writes: "At no life period is it too early or late to prepare for the next one." One should not accept this statement without question. It promotes procrastination, engenders false security in the unprepared, and invites many who grow old to founder in the 'safe' harbor of old age. Sometimes it *is* too late.

Unfortunately, youthful readers are disinterested in learning how to grow old wisely because Age lies too far afield. And the old will come to the book too late for the help it affords.

Nevertheless, the potential audience that may be helped is overwhelming. There remains a group of at least 30,000,000 of the middleaged, with fairly resilient muscles and elastic minds, who can pick up *Aging Successfully*, read it and put it down, having become better fortified to face the exigencies of oncoming age.

The book's fifteen chapters are saturated with sympathetic understanding for the problems of the old and the aged. One senses immediately that the author is steeped in his work; that he comes by his knowledge of the subject

## NEW BOOKS IN REVIEW

### THE PSYCHOANALYTIC STUDY OF THE CHILD.

Vol. II, 1946. Editorial Board: United States, Phyllis Greenacre, M.D., Heinz Hartmann, M.D., Edith B. Jackson, M.D., Ernst Kris, Ph.D., Lawrence S. Kubie, M.D., Bertram D. Lewin, M.D., Marian C. Putnam, M.D., Rudolph M. Loewenstein, M.D., René A. Spitz, M.D.; Great Britain, Anna Freud, Willie Hoffer, M.D., Ph.D., L.R.C.P., Edward Glover, M.D. New York: International Universities Press. 1947. 424 p. \$7.50

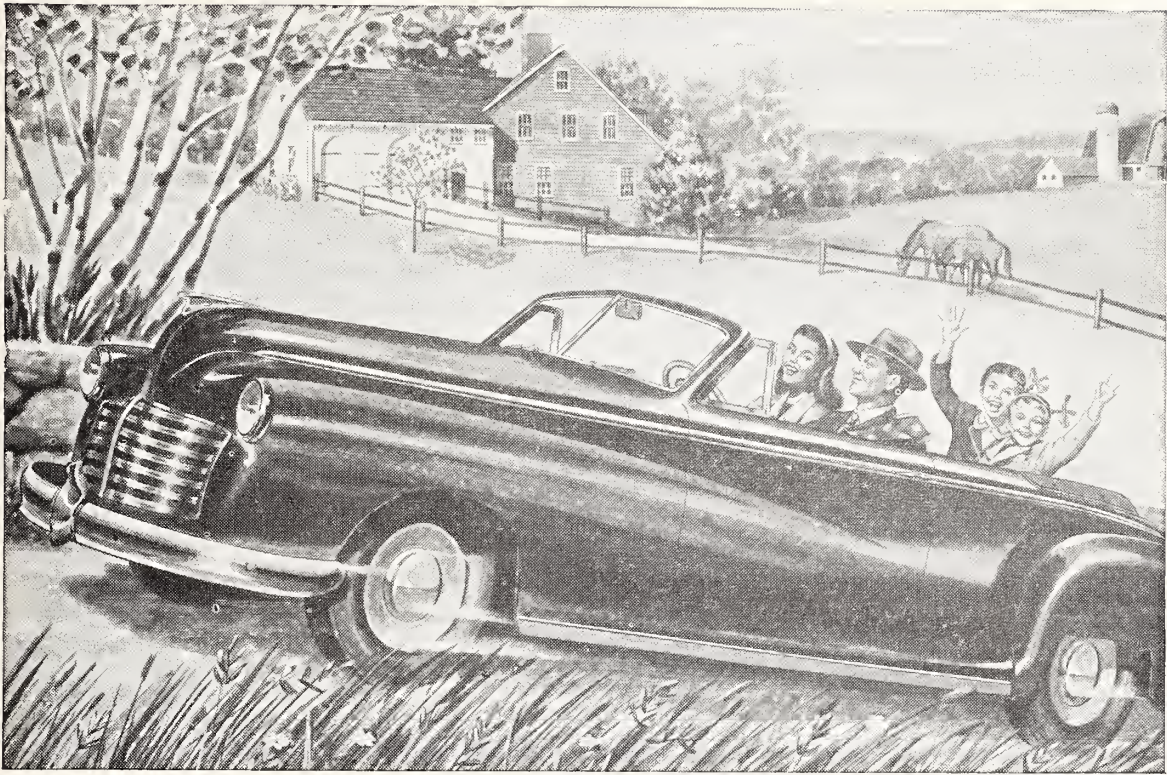
Reviewed by C. C. BURLINGAME

This second volume of the Psychoanalytic Study of the Child covers a wide range of subjects in the field of child psychology and child psychiatry, with particular emphasis on problems of development and of clinical reference. The papers which compose it, 21 in number, are of various authorship, well prepared and documented and illustrated with many excellent case histories.

The clinical aspects considered range from such frequent problems as infantile feeding disturbances, reading disabilities and enuresis to the rarer psychotic pictures in childhood. The first case of a child analysis to be reported in detail, a case of night terror presented in 1930 by Jenny Waelder Hall, is included in this volume. It remains outstanding in the field.

The importance of very early experience in determining personality configuration as well as emotional, behavioral, and psychosomatic patterns is consistently highlighted in





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not only by reading about the old but actually by rubbing shoulders with them and experiencing their frustrations, loneliness and infirmities.

George Lavton illuminates for us the dark corners of the oldster's mind and examines the various levels of his emotions. And so, the oldster emerges as an important individual; not as a forgotten one who is relegated to the cold-ash-pile of bitter memories.

There is much in these pages for the physician with conscience and heart. The book helps to revitalize his dormant interest in his 'old chronic case'; it helps to transform the aged one (in the physician's mind) into a human being with hopes, fears and discomforts. Too many of us lightly dismiss the 'old chronic' and his complaints because we believe there is so little one can do to help. Often, there is much.

*Aging Successfully* is highly recommended to physicians as an artful study in the management of the old. The title speaks for itself. The author has spread out aptly and generously a formula which invites our careful consideration if we are to derive practical benefits in handling candidates for old age—and those already in that category.

**A TEXTBOOK OF MEDICINE.** (Seventh Edition.)  
*Edited by Russell L. Cecil, A.B., M.D., Sc.D.,* Professor of Clinical Medicine, Cornell University Medical College; Consulting Physician, New York and Veterans' Hospitals;

Visiting Physician, Bellevue Hospital, New York City. With assistance of Walsh McDermott, M.D., Associate Professor of Medicine, Cornell University Medical College. Associate Editor for Diseases of the Nervous System: *Harold G. Wolff, M.D.,* Associate Professor of Neurology, Cornell University Medical College. 1730 pages, with 244 illustrations. *Philadelphia and London: W. B. Saunders Co.* 1947. \$10.

Reviewed by ARTHUR BLISS DAYTON

To review the seventh edition of Cecil's *Medicine* only four years after the last has been less a task than a quiet but thrilling pleasure. Turning the leaves of the two volumes one notes with sadness a few old familiar names are missing. Others taking their place continue to maintain the high standard of previous editions. New clinical entities are defined, new therapies are described and here and there one detects a change in emphasis. Even the medical aspects of the atomic bomb are considered and I pause and wonder if there ever will be an eighth edition. The kaleidoscope of progress! But, here and now, how can one practice medicine without a volume such as this at one's elbow?

The format is improved for purposes of reference but the index still fails at times to make a hurried check easy and the thought comes that it could be easily amplified into a glossary where diseases and syndromes with proper names,

## ORTHOPEDIC SURGERY IN CONNECTICUT

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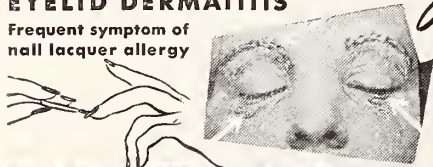
## HISTORY OF ORTHOPEDIC SURGERY IN CONNECTICUT

*written by DR. PAUL SWETT of Hartford*

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et cetera, could more quickly be run down. The pages have increased from 1566 in the sixth edition to 1730 in the seventh and if there is to be an eighth edition it well might be proper to suggest that a dictionary stand be furnished.

**DISEASES OF THE CHEST: WITH EMPHASIS ON X-RAY DIAGNOSIS.** By *Eli H. Rubin, M.D., F.A.C.P., F.C.C.P.*, Attending Physician, Division of Pulmonary Diseases, Montefiore Hospital and Country Sanatorium, New York; Visiting Physician in Tuberculosis and Physician-in-charge, Chest Clinic, Morrisania City Hospital, New York. 685 pages, with 355 illustrations (24 plates in color). Philadelphia and London: W. B. Saunders Company. 1947. \$12.

Reviewed by N. A. MARINARO

The text consists of six sections, 355 illustrations, 24 color plates, numerous brief clinical histories, and extensive bibliographies.

The sections are treated as entities, each concerning a specific field. Herein, the broader concept of diseases of the chest is covered without neglecting the basic aspects.

Anatomy, pathology, physiology, bacteriology, roentgenology, physical-diagnosis, and therapy are adequately blended in order to present the modern and recent concept of this rapidly expanding phase of medicine. A detailed dis-

cussion of any particular aspect is avoided in this book.

The authors demonstrate and record an extensive knowledge of diseases of the chest. Happily so, because this steered them around that pitfall of texts, namely, a repetition of ancient and disproven observations which are outmoded by newer concepts.

The following excerpts from the conclusion of section four, which is devoted to physical diagnosis, illustrates this point: "The elicitation of abnormal physical signs is of value in diagnosis of lung-disease; the lack of signs does not indicate the absence of disease; advanced pathological changes may be present in both lungs without demonstrable physical signs."

The illustrations and color plates are clear, instructive, and faithfully reproduced. These, in conjunction with the brief clinical histories, seem to emphasize the particular points under consideration.

The bibliographies placed at the end of each section are extensive. They afford the reader ample opportunity for further study of any particular subject.

This book is good. It affords any physician, so interested, a comprehensive panorama of the vast field of diseases of the chest. Any reader will and should appreciate that diseases of the lungs include more than pneumonia and tuberculosis.





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and contains only the points of value in each article. The volumes are well indexed and the articles are placed under appropriate headings.

Such a collection of reviews is not adapted for teaching purposes but serves as a good reference since the articles contain useful statistical data. They should be exceptionally useful to physicians who were in the armed forces and who had no access to the many journals and papers written during the war years. For example, much is presented on caudal analgesia, its indications, usage, contra-indications and complications; the Rh factor, its determination and usefulness; penicillin therapy for syphilis and gonorrhea in the female; vaginal smears in diagnosis of endocrine imbalances, and diagnosis of cancer of the uterus. These are only a few of the vast number of new subjects reviewed by many different writers from their experiences.

Also these volumes should be particularly useful to physicians other than specialists in obstetrics and gynecology, inasmuch as they present in condensed form the results of the new developments and practices in these fields. They enable the reader to avoid the perusal of many long articles in as many different journals. To the specialist in obstetrics and gynecology these books should be useful for quick reference without the necessity of filing large numbers of out-of-date journals. The varied opinions on the same subjects give the reader an advantage in deciding which is the most tenable.

The foresight and effort of the publisher has been well worth while in bringing a yearly condensation of specialty reviews to the medical profession.

**QUARTERLY REVIEW OF OBSTETRICS AND GYNECOLOGY.** 3 Volumes—1943, 1944 and 1945. By Board of Editors consisting of 30 leading specialists, aided by the permanent Library Research staff of the Washington Institute of Medicine. Washington, D. C.: Washington Institute of Medicine. Reprinted 1946. 2,193 pages. \$25.00 a set.

Reviewed by ASA S. WATSON

These three volumes are well bound, printed on excellent paper in large, easily read type. The contents are, in themselves, only short reviews of articles pertaining to gynecology and obstetrics published in other journals, both foreign and national. Each review is short, concise, easy to read,

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 1939 Wolfson, Dexter, 58 Greenwood Ave.

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 1921 Booe, John Grady, 144 Golden Hill  
 1947 Braun, Rudolf, 525 Clinton Ave.  
 1941 Brier, Hyman David, 2583 Main  
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 1940 Brooks, Paul Lester, 1260 East Main  
 1939 Buckhout, George Atherton, 144 Golden Hill  
 1938 Buckley, John William, 2080 North Ave.  
 1923 Buckmiller, Frank Charles, 1119 Stratford Ave.  
 1940 Burns, Bernard John, 1101 East Main  
 1919 Calvin, Claudius Virgil, 144 Golden Hill  
 1945 Capobianco, Arthur Paul, 932 East Main  
 1946 Cardone, Michael James, 2989 Main  
 1920 Carroll, Francis Patrick, 919 Fairfield Ave.  
 1932 Carroll, Philip Roger, Jr., 1131 Noble Ave.  
 1947 Caserta, Silvio Joseph, 880 North Ave.  
 1940 Castaldo, Louis F., 942 Valley Rd.  
 1920 Cheney, Maurice Lionel, 144 Golden Hill  
 1941 Clark, William Thompson, 881 Lafayette

1924 Conklin, Cornelius Stephen, 468 Clinton Ave.  
 1936 Connors, Edwin Robert, 416 Boston Ave.  
 1935 Creaturo, Nicholas Edward, 1286 East Main  
 1943 Crispin, Maximilian A., 1278 East Main  
 1913 Curley, William Henry, 881 Lafayette  
 1947 Curley, William Henry, Jr., 881 Lafayette  
 1908 Curran, Philip John, 144 Golden Hill  
 1894 Day, Fessenden Lorenzo, 819 Myrtle Ave.  
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 1935 Del Vecchio, Leonard Frederick, 932 East Main  
 1947 Deren, Moses David, 562 Boston Ave.  
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 1947 Donadeo, John, 1776 North Ave.  
 1945 Donnelly, William Augustus, 2112 North Ave.  
 1941 Duzmati, Paul Peter, 258 Kent Ave.  
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 1946 Eskwith, Irwin Stanley, 881 Lafayette  
 1939 Esposito, Joseph John, 144 Golden Hill  
 1938 Findorak, Francis George, 230 Hickory  
 1943 Fink, Lisbeth, 3166 Main  
 1913 Finkelstone, Benjamin Brooks, 144 Golden Hill  
 1938 Foley, Francis Xavier, 3100 Main  
 1916 Gade, Carl Johannes, 144 Golden Hill  
 1939 Gaffney, Charles Bernard, 610 Brooklawn Ave.  
 1929 Garbelnick, David Abraham, 1102 East Main  
 1907 Gardner, Charles Wesley, 144 Golden Hill  
 1916 Garlick, George Burroughs, 144 Golden Hill  
 1940 Geer, William Allyn, 881 Lafayette  
 1916 Gilday, James Lowry, 819 State  
 1927 Gildea, Mark Andrew, 881 Lafayette  
 1895 Gold, James Douglas, 839 Myrtle Ave.  
 1943 Golomb, Evelyn Frances, 2583 Main  
 1946 Goodrich, William J., 3120 Fairfield Ave.  
 1927 Greenspun, David Stoven, 144 Golden Hill  
 1916 Griffin, Daniel Patrick, 1278 East Main  
 1923 Griswold, Arthur Sheldon, 144 Golden Hill  
 1928 Griswold, Crawford, 144 Golden Hill  
 1920 Groark, Owen James, 881 Lafayette  
 1943 Grossman, John Henry, 144 Golden Hill  
 1941 Gulash, John Robert, 573 Stillman  
 1913 Hale, Fraray, 144 Golden Hill  
 1941 Hall, Rufus Warren, 66 Park  
 1947 Hanley, James Leo, Jr., 928 Lafayette  
 1939 Hardenbergh, Daniel Bailey, 144 Golden Hill  
 1928 Harshbarger, Isaac Long, 144 Golden Hill  
 1946 Hart, Benjamin Ide, 453 State  
 1920 Havey, Leroy Austin, 144 Golden Hill  
 1938 Hennessey, Joseph Gerard, 482 Brewster  
 1915 Hippolitus, Paul DiFrancesca, 269 Barnum Ave.  
 1930 Hooper, G. Herbert, 1633 East Main



1933 Horn, Benjamin, 754 Clinton Ave.  
1916 Horn, Martin Irving, 915 North Ave.  
1920 Howard, Joseph Henry, 144 Golden Hill  
1938 Hurlburt, Edward Glens, 3366 Main  
1912 Hyde, Charles Elias, 881 Lafayette  
1932 James, Arthur Gregory Boswell, 1424 Stratford Ave.  
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1941 Kaufman, William, 541 Brooklawn Ave.  
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1946 Kinder, Frederick Stephen, 144 Golden Hill  
1946 Kleinman, Harold Louis, 2051 North Ave.  
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1904 Lynch, Robert Joseph, 144 Golden Hill  
1947 Lynch, Vincent Aloysius, 928 Lafayette  
1944 Lyon, Grover Arthur, 2009 North Ave.  
1932 Marglis, Ben, 171 Harrison  
1941 Martin, Raymond Alfred, 144 Golden Hill  
1942 Massey, Daniel M., 1025 Noble Ave.  
1922 Maxwell, John Alphonsus, 254 East Main  
1945 McGovern, Edward F., 881 Lafayette  
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1913 McQueeney, Andrew Michael, 1315 Noble Ave.  
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1892 Miles, Henry Shillingford, 144 Golden Hill  
1947 Molnar, George J., 261 Clinton Ave.  
1940 Monahan, David Tuite, 144 Golden Hill  
1932 Mooney, Sydney, 881 Lafayette  
1936 Murray, William Joseph, 144 Golden Hill  
1938 Nespeco, James V., 3180 Main  
1901 Nettleton, Irving La Field, 775 Washington Ave.  
1919 Neumann, Harry Aaron, 588 State  
1937 Newton, Louis, 881 Lafayette  
1925 Nichols, Charles Williams, 1221 Stratford Ave.  
1920 Nickum, John Stanley, 144 Golden Hill  
1936 Nolan, John Francis, 1260 East Main  
1947 Northman, Frank Fred, 1884 Park Ave.  
1926 Oberg, Frank Thorwald, General Electric Co.  
1941 O'Connell, John Gabriel, 265 Washington Ave.  
1943 O'Neill, John Joseph, 1468 Stratford Ave.  
1944 Oros, Louis Michael, 555 Clinton Ave.  
1944 Oster, Kurt A., 881 Lafayette  
1947 Owens, Andrew Paul, 385 Noble Ave.  
1940 Panettieri, Andrew Joseph, 3084 Main  
1942 Parker, Ralph Layton, 928 Lafayette  
1921 Parmelee, Berkley Melvin, 144 Golden Hill  
1937 Pascal, Thomas J., 1560 Noble Ave.  
1944 Pasquariello, Domenico William, 2969 Main  
1946 Pellens, Mildred, 1278 East Main

1930 Pileggi, Peter, 743 Washington Ave.  
1932 Pitock, Morris Philip, 881 Lafayette  
1935 Plukas, Joseph Martin, 339 South Ave.  
1942 Popkin, Michael Sherman, 1671 Noble Ave.  
1941 Pratt, George Kenneth, 881 Lafayette  
1933 Quatrano, Joseph Charles, 893 Clinton Ave.  
1916 Quinn, John Francis, 144 Golden Hill  
1941 Quinn, Katherine Sarah, 2970 North Main  
1916 Reich, Upton Sharetts, 2095 Main  
1940 Reiter, Benjamin Reynolds, 144 Golden Hill  
1942 Resnik, Harry, 881 Lafayette  
1938 Ribner, Harold, 928 Lafayette  
1918 Roberts, Edward Russell, 144 Golden Hill  
1913 Roche, Thomas Joseph, 1815 Noble Ave.  
1936 Rockwell, Alice Elizabeth, 1775 Noble Ave.  
1944 Rosenberg, Hans August, 1621 East Main  
1946 Rosenberg, Saul, 1950 Park Ave.  
1946 Rosner, Fred, 1166 Fairfield Ave.  
1942 Scalzi, Leonard Conrad, 932 East Main  
1946 Schopick, Louis E., 2090 North Ave.  
1943 Sciortino, Michael Vincent, 2072 North Ave.  
1947 Scully, Michael Richard, 3265 Main  
1928 Sekerak, Arthur Joseph, 408 Barnum Ave.  
1938 Sekerak, Raymond Andrew, 1400 East Main  
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1938 Shea, Cornelius Joseph, 1153 Park Ave.  
1913 Shea, John Francis, 144 Golden Hill  
1946 Sheiman, Milton, 1539 Park Ave.  
1946 Sheiman, Samuel Charles, 1539 Park Ave.  
1947 Sherman, Benjamin, 880 North Ave.  
1944 Sholler, Nicholas A., 2148 North Ave.  
1947 Siege, Alfred Geoffrey, 2089 North Ave.  
1939 Simses, John Peter, 144 Golden Hill  
1935 Smith, Joseph Jacob, 1280 Stratfield Rd.  
1919 Smith, Stanton Reinhart, 144 Golden Hill  
1913 Smykowski, Bronislaw Louis, 405 Barnum Ave.  
1930 Sollosy, Alexander, 1430 Fairfield Ave.  
1941 Spinelli, Nicholas Victor, 1285 Noble Ave.  
1909 Sprague, Charles Harry, 29 Hanover  
1935 Strayer, Luther Milton, Jr., 144 Golden Hill  
1940 Tarasovic, Thomas Joseph, 123 Churchill Rd.  
1920 Taylor, Clifton Clark, 881 Lafayette  
1938 Ter Kuile, Roger Couvelle, 881 Lafayette  
1925 Tolk, Nathan Robert, 558 Clinton Ave.  
1942 Trautman, Edwin Frederick, 5385 Main  
1929 Turchik, Frank, 1831 Barnum Ave.  
1947 Turetsky, Samuel, 2718 Fairfield Ave.  
1941 Tutles, Alexander James, 860 Clinton Ave.  
1943 Unger, Milton, 1025 Central Ave.  
1932 Uvitsky, Irving Harry, 3101 Main  
1947 Veneruso, Leonard Charles, 1690 Barnum Ave.  
1941 Vioni, R. Edward, 880 North Ave.  
1942 Ward, James P., 881 Lafayette  
1903 Warner, George Howell, 144 Golden Hill  
1920 Watts, Joseph Francis, 881 Lafayette  
1913 Weadon, William Lee, 144 Golden Hill  
1934 Wehger, Roland Theodore, 144 Golden Hill  
1922 Weise, Ellwood Carl, 144 Golden Hill  
1947 Yasser, Isidore, 1302 Stratford Ave.  
1936 Yeager, Charles Frederick, 2139 East Main  
1935 Zaur, Israel Sidney, 881 Lafayette  
1946 Zavadier, Nathan, 68 Ocean Ave.  
1947 Zielinski, John Blaise, 562 Boston Ave.  
1943 Zsiga, Elmo Douglas, 303 Clinton Ave.

DANBURY

1929 Amos, Isadore Louis, 323 Main  
1929 Booth, John Dibble, 173 Main

1941 Brochu, Eugene Dalva, 229 Main  
 1902 Bronson, William Thaddeus, 41 West  
 1942 DeKlyn, Ward B., 177 Main  
 1928 Delohery, Cornelius Leo, 65 Main  
 1935 Driscoll, Jerome James, 206 Main  
 1937 Eckert, George Robert, 394 Main  
 1947 Edson, Dean Harding, 75 West  
 1947 Epstein, Benjamin, 8 Locust Ave.  
 1935 Fox, Robert Adolph, 95 Locust Ave.  
 1931 Gaffney, John James, 265 Main  
 1931 Genovese, Frank Thomas, 172 White  
 1938 Genovese, Serafino, 390 Main  
 1930 Gibson, Donald Farnham, 75 West  
 1929 Goldys, Frank Max, 209 Main  
 1897 Gordon, William Francis, 26 West  
 1940 Howard, Leonard Arnold, 87 West  
 1946 Lipton, Harold, 8 West  
 1912 Mullins, Samuel Frederick, 116 Main  
 1937 Murphy, James Joseph, 147 Main  
 1939 Murray, Thomas Oscar, 75 West  
 1937 Rogol, Louis, 85 West  
 1926 Selleck, Nathaniel Benedict, 215 Main  
 1913 Smith, Arthur Charles, 246 Main  
 1920 Stahl, William Martin, 343 Main  
 1907 Sunderland, Paul Ulysses, 160 Deer Hill Ave.  
 1929 Sunderland, William Alexander, 158 Deer Hill Ave.  
 1932 Tomaino, Felix Francis, 8 West  
 1943 Weiner, William, Danbury Hospital  
 1947 Yoburn, Michael Myer, 65 West

## DARIEN

1944 Huntington, Frederic Sargent, Middlesex and Hollow  
 Tree Ridge Rd.  
 1941 Moore, Gilbert Emerson, 178 Post Rd.  
 1940 Ross, Allan Maxwell, 188 Post Rd.  
 1938 Van Tassel, Walter, 194 Post Rd.  
 1946 Voris, Jacques Van Brunt, 22 Old King's Hwy.

## FAIRFIELD

1944 Barker, Daniel C., 133 Reef Rd.  
 1939 Biehn, Donald M. Frick, 1275 Post Rd.  
 1928 Biehn, Sidney Lister, 22 Reef Rd.  
 1946 Conner, Edward Dew, 1330 Post Rd.  
 1935 Davis, Thomas Francis, 1583 Post Rd.  
 1947 Grimm, Homer Willard, 413 Mill Hill Ter.  
 1944 Harris, H. Patterson, Jr., 1432 Post Rd.

## GREENWICH

1940 Adams, Mary, 149 Field Point Rd.  
 1935 Amoss, Harold Lindsey, 21 Field Point Rd.  
 1939 Anderson, Clifton Winthrop, 116 East Elm  
 1938 Carter, Gray, 29 Hillside Dr.  
 1943 Claps, Ludovic Vincent, 161 Mason  
 1933 Close, John Frederick, 66 Millbank Ave.  
 1944 Davol, Rector Thomson, 63 North  
 1945 Fisher, Joseph G., Ituri Towers  
 1937 Gates, Aaron Billings, 305 Millbank Ave.  
 1945 Gratz, Charles Murray, 40 West Elm  
 1940 Grigas, John E., 56 East Elm  
 1942 Halloran, James Vincent, 161 Mason  
 1947 Hansell, Robert Joseph, 45 East Putnam Ave.  
 1937 Hawthorne, Julian, Greenwich Towers  
 1944 Kelemen, Eugene, 1 West Elm  
 1927 Knapp, Charles Stanley, 18 Field Point Rd.  
 1918 Knapp, Charles Whittemore, 43 Maple Ave.  
 1940 Larimore, Louise D., 100 Lake Ave.  
 1933 Lockwood, Jane, 271 Lake Ave.  
 1932 McCreery, John Alexander, 43 Maple Ave.

1930 Miller, John, 63 North  
 1944 Morrissett, Leslie Emerson, 261 Lake Ave.  
 1924 O'Donnell, Thomas James, 224 Milbank  
 1939 Reynolds, Whitman Mead, 30 Maher Ave.  
 1935 Rogers, Robert Page, 111 North  
 1946 Rourke, Thomas Alfred, 161 Mason  
 1938 Serrell, Howard P., 43 Maple Ave.  
 1940 Shaw, Lillian Eloise, 45 Field Point Rd.  
 1943 Squier, Raymond R., 40 West Elm  
 1940 Swarts, William B., Warwick Towers  
 1937 Thompson, Sidney Attilio, 161 Mason  
 1940 Tiebout, Harry Morgan, Blythewood  
 1934 Tinkess, Donald Ewing, Stanwich Rd.  
 1939 Tunick, George L., 193 Mason  
 1933 Vickers, James Leonard, 40 West Elm  
 1942 Weber, Frederick Clarence, Jr., 92 Mason

## Cos Cob

1940 Ayres, Payson Bryan, 10 Old Post Rd.  
 1912 Bergin, Thomas Joseph, 2 Mead Ave.  
 1940 Bria, William Francis, 525 East Putnam Ave.

## OLD GREENWICH

1926 Kaprielian, Haigazoon Kruger, 312 South Beach Ave.  
 1936 Kelly, J. Colman, 30 Highview Ave.  
 1939 Read, Francis Arnold, 292 Sound Beach Ave.  
 1929 Shermak, Joseph V., 13 Arcadia Rd.

## MONROE

## STEPNEY DEPOT

1912 Wales, Francis Joseph  
 1946 Williams, Francis Pryor Anthony

## NEW CANAAN

1937 Abrahams, Meyer, 191 South  
 1942 Bradley, Edwin Tremain, 28 Elm  
 1933 Bucciarelli, John Anthony, 93 East Ave.  
 1939 Cammann, Oswald DeNormandie, Oenoke Ave.  
 1941 Cody, Thomas Patrick, 222 South Main  
 1938 DuBois, Franklin Smith, Silver Hill  
 1939 Frothingham, John Gerrish, 149 South Main  
 1941 Hebard, George Whiting, Elm  
 1945 Hiden, Robert Bataille, Silver Hill  
 1935 Ludlow, George Craig, 8 Oenoke Ave.  
 1945 Pearce, Marvin Ghent, Silver Hill  
 1935 Terhune, William Barclay, Silver Hill  
 1941 Twachtman, Eric, 28 Elm  
 1931 Wadsworth, Ruth Flanigen, Smith Ridge  
 1944 White, Ralph L., 178 South Main

## NEWTOWN

1934 Clow, Henry Leon, Fairfield State Hospital  
 1927 Desmond, Waldo Fairfield, Main  
 1937 Egee, J. Benton  
 1941 Friedman, Samuel, Fairfield State Hospital  
 1940 Green, William Frederick, Fairfield State Hospital  
 1935 Grout, Stillman Proctor, Fairfield State Hospital  
 1947 Kyle, George Byron, Glen Rd., Sandy Hook  
 1941 Oltman, Jane Elizabeth, Fairfield State Hospital  
 1947 Stephens, Duncan C., Fairfield State Hospital

## NORWALK

1945 Corwin, Daniel Bernard, 463 West Ave.  
 1937 Diamond, Edward H., 15 Belden Ave.  
 1940 Fitzpatrick, Wesley Fenton, 85 East Ave.  
 1946 Gens, John Paul, 64 Wall  
 1938 Gorham, Grace Viola, 64 Wall  
 1945 Johnson, William Henry Nelson, Jr., 14 Leonard



1915 Kellogg, Henry Kirke White, 725 West Ave.  
1938 Northrop, Robert Arthur, 64 Wall  
1947 Ogden, Faith Newbury, 6 Stevens  
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1929 Patterson, Frederick Arthur, 520 West Ave.  
1942 Paul, Francis, 64 Wall  
1930 Perkins, Charles Winfield, 520 West Ave.  
1920 Perry, Mabelle Jeane, 676 West Ave.  
1938 Piasecki, Joseph L., 520 West Ave.  
1928 Scanlon, Thomas Francis, 394 West Ave.  
1941 Shain, Joseph H., 520 West Ave.  
1929 Tracey, Edward John, 637 West Ave.  
1890 Tracey, William Joseph, 637 West Ave.  
1938 Vollmer, John William, 654 West Ave.  
1934 Wallace, Victor George Henry, 55 Wall  
1938 Weinstein, Nathan, 471 West Ave.  
1943 Willis, Thayer, Bettswood Rd.

SOUTH NORWALK

1936 Beck, Eugene Cornelius, 75 South Main  
1918 Bradley, Theron Robert, 9 Washington  
1946 Burack, Jason Oliver, 3 West Ave.  
1941 Cody, George Richard, 61 South Main  
1938 Corridon, James Donald, 47 Seaview Ave.  
1943 Davis, James Sumner, 2 Gibson Court  
1922 Fawcett, George Gifford, 8 Washington  
1941 Flanagan, Edwin Daniel, 141 West Ave.  
1938 Giuliano, Louis Augustine, 84 West Ave.  
1941 Green, H. Howard, 75 South Main  
1940 Heafey, John Robert, 84 West Ave.  
1938 Hunkemeier, Edna, 3 Washington  
1938 Keys, Robert Cathcart, 84 West Ave. and 322 Main, Stamford  
1941 McMahon, John David, 4 Washington  
1923 McMahon, William Henry, Jr., 13 Washington  
1946 Mills, Clifford Wheeler, 84 West Ave.  
1938 Paris, Marcus, 34 West Ave.  
1941 Rosenthal, Isidor, 72 South Main  
1939 Scanlon, John Joseph, 276 West Ave.  
1946 Serena, John Mario, 84 West Ave.  
1946 Sikes, Ralph Fuller, 7 Franklin  
1931 Simon, Louis Goodwin, 30 West Ave.  
1943 Steinberger, Lazslo, 96 South Main  
1937 Stietzel, Eric Ernst, 5 Washington

RIDGEFIELD

1937 Bell, Joseph Sloane, 54 Main  
1947 Burgess, Forbes Hathaway, 126 Main  
1944 Inkster, James Henry, 153 Main  
1946 Pease, Marshall Carleton, Branchville Rd.  
1927 Woodford, Francis Bowditch, 62 Main

RIVERSIDE

1945 Meeker, David Olan, Riverside Ave.

SHELTON

1945 Burns, Francis Michael, 499 Howe Ave.  
1939 Edson, Ralph Howard, 77 Oak Ave.  
1917 Finn, Edward James, 452 Howe Ave.  
1930 Gaetz, Thomas Harold, Laurel Heights  
1937 Howlett, Kirby Smith, Jr., Laurel Heights  
1925 Lynch, Edward James, Laurel Heights  
1941 Pagliaro, Joseph John, 433 Howe Ave.  
1895 Randall, William Sherman, 241 Coram Ave.

STAMFORD

1946 Abrahamson, Robert H., 107 Glenbrook Rd.  
1937 Aldwin, Francis Joseph, 295 Atlantic

1936 Bannon, Frederick Michael, 300 Main  
1947 Barber, Richard Robbins, 77 Bedford  
1907 Barnes, Frank Haslehurst, Dr. Barnes Sanitarium  
1947 Beaman, George Burnham, 322 Main  
1927 Bissell, Addison Hayes, 65 South  
1944 Blass, Gustaf, Stamford Hall  
1926 Bowman, Stuart Howard, 65 South  
1928 Brown, Paul Hemingway, 140 Woodside Village  
1935 Carpenter, Robert Morse, 636 Summer  
1937 Carwin, Joseph Lucian, Jr., 115 West Main  
1944 Cassone, Rocco, 308 Atlantic  
1947 Choutzu, Pei, 197 Main  
1940 Cognetta, James John, 228 West Broad  
1946 Colburn, Russell Fitch, 1416 Bedford  
1942 Colmers, Rudolph Albert, 295 Atlantic  
1940 Connolly, Joseph Patrick, 104 South  
1937 Costanzo, James Joseph, 300 Main  
1940 Crane, James Everett, 50 Glenbrook Rd.  
1909 Crane, Ralph William, 50 Glenbrook Rd.  
1937 Cunningham, Robert D. M., 65 South  
1934 D'Andrea, Frank Henry, 29 South  
1938 Dean, Stanley Rochelle, 322 Main  
1909 Dichter, Charles Levi, 33 Forest  
1935 Dichter, Irving Samuel, 33 Forest  
1947 DiFrancesco, Lindo Peter, 65 South  
1947 Dobkins, John Jacob, 81 Atlantic  
1937 Dorion, Robinson Harry, 610 Summer  
1947 Felding, Howard Anthony, 300 Main  
1933 Fincke, Charles Louis, 1 Atlantic  
1937 Fine, Barnet, 70 Grove  
1936 Fine, Joseph, 55 Forest Rd.  
1931 Fiske, Madeline, 77 Bedford  
1934 Friedberg, Solomon, 671 Bedford  
1931 Gandy, Raymond Alfred, 65 South  
1913 Gandy, Raymond Reeves, 65 South  
1931 Giles, Newell Walton, 1 Atlantic  
1945 Greenblatt, Jacob, 67 Forest  
1929 Hamilton, John Stewart Marshall, 58 South  
1937 Harrison, Francis Murphy, 512 Atlantic  
1908 Harrison, John Francis, 512 Atlantic  
1916 Henderson, Alfred Collard, 55 Glenbrook Rd.  
1935 Henderson, Jean, 70 Strawberry Hill Ave.  
1930 Hertzberg, Reinhold Frederick, 31 West Park Pl.  
1937 Hopper, Edward Bernard, 65 South  
1937 Hymovich, Leo, 1521 Summer  
1944 Jaiven, Saul Joseph, 1521 Summer  
1929 Keddy, Russell Alfred, Stamford Hospital  
1938 Kezel, Albert Patrick, 188 Grayrock Pl.  
1939 Koffler, Arthur, 90 Glenbrook Rd.  
1947 Leong, Ellen Fooklen, 197 Main  
1934 Malloy, Edvard Francis, 65 South  
1946 Mastrangelo, Angelo, Jr., 29 South  
1933 McFarland, Frederick William, 65 South  
1928 McGourty, Andrew Frederick, 7 Glenbrook Rd.  
1935 McGourty, David Philip, 70 Strawberry Hill  
1924 McMahon, Frank Cash, 62 Suburban Ave.  
1947 Meacham, Charles Thomas, 65 South  
1930 Meschter, Eugene Funk, Yale & Towne Mfg. Co.  
1946 Miller, Hugh Kennedy, 970 Summer  
1936 Moore, Clifford Douglas, Stamford Hall  
1938 Murphy, Charles Anthony, 59 South  
1931 Murray, Henry Joseph, 53 South  
1940 Nemoitin, Bernard Oscar, 96 Main  
1911 Nemoitin, Jacob, 96 Main  
1946 Ogilvie, John Black, 610 Summer  
1938 O'Meara, Francis Patrick, 1 Elm Pl.  
1946 Paley, I. Martin, 322 Main  
1928 Paul, Voyle Abrams, 65 South  
1946 Poczabut, John Stephen, 65 South

- 1938 Rawls, Edward Cotton, 300 Main  
 1929 Resnik, William Harry, 65 South  
 1942 Robison, Roy Calvin, 65 South  
 1936 Rose, Samuel Allison, 65 South  
 1943 Ryder, Clifford Fuller, 77 Bedford  
 1929 Rynard, William Morvel Wesley, 29 South  
 1946 Sábía, Daniel Joseph, 15 Broad  
 1932 Schmidt, Norman Louis, 60 Glenbrook Rd.  
 1930 Sette, Alfred Joseph, 78 Forest  
 1938 Sherman, Saul Harvey, 328 Atlantic  
 1941 Smith, Leo Michael, 65 South  
 1917 Smith, William Earl, 65 South  
 1947 Snaveley, John Geoffrey, Stamford Hospital  
 1946 Soresi, Angelo Louis, 200 Weed Ave.  
 1942 Stankard, William Francis, 140 Forest  
 1934 Starrett, Jay Ellis, 970 Summer  
 1907 Staub, John Howard, 100 South  
 1931 Stone, Merlin Jones, 76 Glenbrook Rd., also 161  
 Mason, Greenwich  
 1920 Stringfield, Oliver Linwood, 1416 Bedford  
 1940 Troy, William Daniel, 612 Bedford  
 1931 Turnley, William Henry, 1 Atlantic  
 1939 Washburn, Wendell James, 65 South, and 261 Lake  
 Ave., Greenwich  
 1937 Weaver, Bruce Stevens, P. O. Box 223  
 1947 Wrona, Eugene Adam, 229 South

## STRATFORD

- 1947 Anton, Michael Charles, 2390 Main  
 1938 Ashcroft, Allan Davis, 3585 Main  
 1941 Benton, Philip Eglín, 972 East Broadway  
 1945 Bliss, Sheldon Pratt, 550 South Main  
 1945 Buda, Gaza Edward, 2362 Main  
 1943 Dinan, Henry Philip, 3466 Main  
 1897 Fleck, Harry Willard, 1 Pauline St., Lordship  
 1936 Friedman, Nathan Harris, 2336 Main  
 1927 Haberlin, Chester Edward, 2944 Main  
 1939 Levy, Samuel Howard, 3007 Main  
 1934 Maher, John Rodden, 2184 Main  
 1946 Morris, Felix Raymond, 523 Nichols Ave.  
 1931 Oesau, Harold Thomas, 1949 Main  
 1940 Penner, Sidney Lincoln, 2692 Main  
 1942 Roberge, George Edward, 44 Plymouth  
 1937 Strayer, Estella Morton, Lordship Rd.  
 1942 Thomas, Saul, 2595 Main

## TRUMBULL

## LONG HILL

- 1946 Corbett, William Tihamer, Box 158  
 1912 Smith, George Arthur

## WESTPORT

- 1943 Berne, Eric Leonard, Westport Sanitarium  
 1944 Blum, Isabelle, 415 Edgewater Hillside  
 1930 Ellrich, David Lionel, 125 East State  
 1943 Gerow, George H., Westport Sanitarium  
 1943 Hart, J. Garwood, 67 Myrtle Ave.  
 1943 Houze, Harry G., Westport Sanitarium  
 1946 Isenman, Robert, 26 West State  
 1934 Morgan, William Oliver, 193 Main  
 1937 Nespor, Robert Venzel, 10 Taylor Pl.  
 1925 Phillips, Harry Shaw, 44 Church Lane  
 1941 Shoup, Homer B., Jr., 58 East State St.  
 1934 Smith, Stephen Munro, 78 Main

- 1943 Solway, Reuben Isaac H., 450 Kings Highway  
 1936 Teuscher, William Philip, 18 Compo Rd.

## WILTON

- 1939 Knauth, Marjorie Strauss, Drum Hill Rd.  
 1944 McCombs, A. Parks, Hurlbutt

## OUT OF COUNTY

- 1939 Brewer, Francis, 860 Park Ave., Bloomfield  
 1943 Cacace, Vincent Anthony, 624 Woodward Ave., New  
 Haven  
 1937 Craighill, Margaret D., 1209 Collins Ave., Topeka,  
 Kansas  
 1937 Harper, Paul, 402 Bretton Pl., Baltimore, Md.  
 1939 Ireland, Richard Milton, 66 Bridge, New Milford  
 1939 Keating, John Joseph, 22 Elm, New Milford  
 1941 Kennedy, Robert Edward, Pinebluff San., Pinebluff,  
 N. C.  
 1941 Knepp, James Warren, 95 Pearl St., Hartford  
 1916 Knowlton, Donald Jerome, Frost Farm, Winthrop, Me.  
 1907 Pratt, Nathan Tolles, Old Saybrook  
 1943 Robey, Nathaniel Charles, Patton State Hospital, Pat-  
 ton, Calif.  
 1909 Shirk, Samuel Martin, Masonic Home, Wallingford  
 1937 Throckmorton, Verl John, Box 71, Kingman, Arizona  
 1920 Tracey, William Wallace, Veterans Hospital, Ft.  
 Whipple, Arizona  
 1942 Upham, Charles E. H., 5 Prospect, New Rochelle, New  
 York  
 1942 Wood, Horatio C., III, 106 North Glen Oak Ave.,  
 Peoria, Ill.  
 1942 Yohn, Albert Klamroth, 1659 34th, N.W., Washington,  
 D. C.

## Hartford County Association

*President:* LOUIS P. HASTINGS, 114 Woodland St., Hartford  
*Vice-President:* CHARLES T. SCHECHTMAN, 81 West Main St.,  
 New Britain  
*Secretary-Treasurer:* W. HOLBROOK LOWELL, 703 Asylum  
 Ave., Hartford  
*Councilor:* C. CHARLES BURLINGAME, 200 Retreat Ave., Hart-  
 ford  
*Business Office:* 38 Prospect St., Hartford

Annual Meeting, First Tuesday in April  
 Semi-Annual Meeting, Fourth Tuesday in October

## AVON

- 1941 Farquhar, Lucille Reed, Main  
 1941 Wiepert, William Murray, Main

## BERLIN

- 1947 Foster, Hollis Joseph, Worthington Ridge  
 1908 Hodgson, Thomas Cady, Worthington Ridge

## BLOOMFIELD

- 1936 Burgdorf, Alfred Louis, Duncaster Rd.  
 1905 Clifton, Harry Coltman, Simsbury Rd.  
 1905 Swett, Paul Plummer, Gun Mill Rd.

## BRISTOL

- 1930 Appell, Paul Harry, 227 Main  
 1943 Barton, Preston Nichols, New Departure Corp.  
 1934 Beatrice, Alphonse Anthony, 331 Main  
 1936 Bird, Frederick Stanford, 124 Main



- 1932 Borkowski, Boleslaus Joseph, 4 School  
 1900 Brackett, Arthur Stone, 321 Main  
 1946 Ciccarelli, Armanno William, 481 North Main  
 1947 Brezina, Philip Savage, 308 Main  
 1934 Donohue, Bartholomev Francis, 481 North Main  
 1935 Flynn, William Henry, 9 North Main  
 1937 Hall, Martin Irving, 269 North Main  
 1946 Hanley, J. Bainbridge, 63 Bellevue Ave.  
 1921 Hanrahan, William Richard, 209 Center  
 1938 Hudon, Frederick Alfred, 321 Main  
 1939 Labuz, Eugene Frank, 342 Main  
 1928 LaPlume, Albert Antonio, 45 Prospect  
 1942 Littwin, Ralph J., Bristol Hospital  
 1929 Nestos, Peter Alexander, 63 Main  
 1935 Papa, John Smith, 124 Main  
 1921 Park, Paul Archibald, 133 Main  
 1921 Richardson, Ralph Augustus, 4 School  
 1922 Robbins, Benjamin Bissell, 47 Main  
 1935 Siliciano, Raoul Andrew Victorius, 110 South  
 1936 Stevenson, William Robb, 124 Main  
 1939 Tirella, Fred Francis, 249 Main  
 1942 Vogel, Frank Siegfried, 301 Main  
 1909 Whipple, Benedict Nolasco, 45 North Main  
 1934 Winters, Hyman W., 405 North Main  
 1914 Woodward, Harold Burton, 321 Main

## CANTON

## COLLINSVILLE

- 1906 Cox, Ralph Benjamin

## EAST HARTFORD

- 1945 Carignan, Roland Zephirin, 74 Connecticut Blvd.  
 1936 Gallivan, John Norman, 74 Connecticut Blvd.  
 1927 Goddard, Harvey Burton, 970 Main  
 1923 Haylett, Howard Bulkeley, 1109 Main  
 1946 Hervey, Zoltan P., 1169 Main  
 1933 Houle, Raymond Theodore, 5 Central Ave.  
 1934 Lublin, Raymond David, 759 Main  
 1937 McCue, Martin Patrick, 1617 Main  
 1939 Mirabile, Thomas Joseph, 59 Burnside Ave.  
 1916 Onderdonk, Harrie Jay, 11 Central Ave.  
 1920 Schaefer, Jacob, 1011 Main  
 1942 Trantolo, Arthur, 1559 Main

## EAST WINDSOR

## BROAD BROOK

- 1923 Robinson, Wilford John Thomas, Main

## WAREHOUSE POINT

- 1937 Maslak, Rudolph, South Main

## ENFIELD

## HAZARDVILLE

- 1906 Bridge, John Law, P. O. Box 272  
 1923 Shepherd, William Gordon, Main

## THOMPSONVILLE

- 1937 Bloom, David Irving, 126 Pearl  
 1937 Dignam, Bernard Stephen, 133 Pearl  
 1938 Gourlie, Howard Wallace, 53 New King  
 1941 Kucewicz, William Joseph, 41 Pearl  
 1917 Vail, Thornton Edwin, 124 Main  
 1940 Valenski, Thaddeus James, Main

## FARMINGTON

- 1946 Barbour, Paul Humphrey, Jr., High  
 1933 Bunnell, Walls Willard, Main  
 1935 MacLean, Ethel Margaret, High

## GLASTONBURY

- 1933 Earle, Benjamin Baylis, 2458 Main  
 1935 Griswold, Edwin Monroe, 28 Ripley Rd.  
 1943 Pharris, Crit, 1252 Main  
 1939 Raffa, Joseph, 2638 Main  
 1946 Ricca, Renato A., 28 Ripley Rd.  
 1924 Whittles, Lee Jay, 2205 Main

## SOUTH GLASTONBURY

- 1908 Ward, James W., 972 Main

## HARTFORD

- 1942 Allen, George Francis, 179 Allyn  
 1944 Allen, Mary Mazner, 179 Allyn  
 1927 Allen, Wilmar Mason, 20 South Hudson  
 1937 Andrews, Egbert Morrill, 576 Farmington Ave.  
 1927 Antupit, Louis, 242 Trumbull  
 1936 Apter, Harry, 1453 Main  
 1932 Arons, Milton Robert, 750 Main  
 1904 Backus, Harold Simeon, 99 Pratt  
 1913 Bailey, Neil Herbert, 550 Main  
 1923 Bancroft, Harold Arthur, 179 Allyn  
 1947 Barbour, Charles Manson, Jr., 20 South Hudson  
 1940 Barker, Norman John, 55 Elm  
 1933 Bausch, Carl Philipp, 36 Pearl  
 1886 Beach, Charles Coffing, 54 Woodland  
 1907 Beach, Charles Thomas, 50 Farmington Ave.  
 1929 Beatman, Israel, 242 Trumbull  
 1944 Beebe, John Taylor, 20 South Hudson  
 1934 Beizer, Edmund, 44 Garden  
 1923 Bestor, Eugene Leonard, 36 Pearl  
 1926 Bidgood, Charles Young, 247 South Whitney  
 1936 Bingham, Charles Tiffany, 576 Farmington Ave.  
 1938 Birge, Henry L., 179 Allyn  
 1941 Bobrow, Aaron, 387 Blue Hills Ave.  
 1897 Botsford, Charles Porter, 219 Collins  
 1941 Brandon, Kenneth Francis, 151 Farmington Ave.  
 1916 Branon, Anthony William, 179 Allyn  
 1912 Brayton, Howard Wheaton, 179 Allyn  
 1931 Brecker, Francis Wellington, 955 Asylum Ave.  
 1939 Brennan, Edward L., 200 Retreat Ave.  
 1931 Brewer, Timothy Francis, 50 Farmington Ave.  
 1946 Brewster, William B., Jr., 179 Allyn  
 1943 Browne, Florence A., 165 Capitol Ave.  
 1942 Bruskin, Chaim Elias, 1840 Park  
 1929 Buck, Burdette Jay, 299 Farmington Ave.  
 1931 Buckley, Richard Cotter, 683 Asylum Ave.  
 1932 Burlingame, Clarence Charles, 200 Retreat Ave.  
 1946 Burness, Sidney Harold, 99 Pratt  
 1928 Butler, Nicholas George, 50 Farmington Ave.  
 1930 Byrne, David Walter, 179 Allyn  
 1942 Cabaniss, Joseph Turner, 700 Main  
 1931 Calverley, Eleanor Jane Taylor, 143 Sigourney  
 1934 Capiello, Silvestro, 97 Vine  
 1933 Carey, Thomas Cornelius, 50 Farmington Ave.  
 1931 Carniglia, Ettore Francis, 50 Farmington Ave.  
 1929 Carroll, James Edward, 220 Farmington Ave.  
 1915 Carter, Earl Buell, 99 Pratt  
 1937 Case-Downer, Muriel, 157 Warrenton Ave.

- 1930 Caulfield, Ernest Joseph, 683 Asylum Ave.  
 1933 Cenci, Vincent Peter, 50 Farmington Ave.  
 1943 Chester, Lewis L., 179 Allyn  
 1940 Clancy, John James, 179 Allyn  
 1935 Clarke, Ralph deBallard, Cedarcrest  
 1922 Clason, Freeman Pell, 179 Allyn  
 1937 Clifford, Martha Louise, 436 Captiol Ave.  
 1931 Climan, Max, 242 Trumbull  
 1928 Cogan, George Eugene, 50 Farmington Ave.  
 1913 Cogswell, Eliot Sanborn, 179 Allyn  
 1936 Cogswell, Lawrence Perley, 179 Allyn  
 1938 Cohn, Samuel Hills, 464 Farmington Ave.  
 1935 Connor, Joseph Joyce, 750 Main  
 1933 Corcoran, Michael Anthony, 689 Asylum Ave.  
 1946 Cornwell, Philip Morba, 179 Allyn  
 1913 Costello, Henry Nicholas, 124 Beacon  
 1933 Crosby, Edward Harding, 50 Farmington Ave.  
 1941 Cullen, James Rescott, 74 Farmington Ave.  
 1936 Cunningham, James Morrow, 165 Capitol Ave.  
 1946 Curran, Timothy Leonard, 689 Asylum Ave.  
 1938 Curtis, Burr Harding, 4 Atwood  
 1914 Daly, Charles William, 750 Main  
 1935 Daly, William Patrick, 342 Edgewood  
 1929 Davenport, Anna Keith Prentiss, 50 Wethersfield Ave.  
 1922 Davis, James Edward, 16 Sunny Reach Dr.  
 1909 DeBonis, Domenico A., 183 Westland  
 1946 Delligan, Francis William, St. Francis Hospital  
 1914 Deming, Clinton Demas, 179 Allyn  
 1914 Deming, Edward Adams, 715 Asylum Ave.  
 1931 DePasquale, Francis Lawrence, 1992 Broad  
 1937 DePasquale, John Anthony, 54 Church  
 1946 Desmond, Charles Thomas, 683 Asylum Ave.  
 1934 DeVito, Michael Joseph, 525 Main  
 1921 Dinsmore, William Wirt, 700 Main  
 1931 Dion, Asa Joseph, 207 Washington  
 1944 Dion, Julien Andre, 207 Washington  
 1939 Dodd, Burwell, 293 Farmington Ave.  
 1944 Doerr, William John, 80 Farmington Ave.  
 1947 Dolce, James A., 165 Capitol Ave.  
 1934 Donner, Samuel, 99 Pratt  
 1938 Donovan, William Francis, 47 Main  
 1937 Duffy, Leo Thomas, 683 Asylum Ave.  
 1942 Duksa, Walter Joseph, 535 Main  
 1938 Durkee, Ralph Everett, Jr., 179 Allyn  
 1946 Dushane, Joseph Edward, 147 Sigourney  
 1916 Dwyer, William, 18 Asylum  
 1947 Ebers, Theodore Martin, 140 Garden  
 1942 Edson, Reginald Campbell, 119 Ann  
 1927 Elliot, K. Gregory, 631 Park  
 1943 Ellis, Lyle Gaffney, 700 Main  
 1937 Ellison, Frederick Speirs, 50 Farmington Ave.  
 1895 Elmer, Edward Oliver, 1731 Park  
 1914 Emmett, Francis Arthur, 410 Asylum  
 1946 Englehart, Ernest Erwyn, 21 Marshall  
 1937 Fagan, Francis Xavier, 683 Asylum Ave.  
 1933 Farland, Victor Louis, 54 Pratt  
 1919 Fay, William James, 179 Allyn  
 1941 Feeney, Thomas Michael, 701 Asylum Ave.  
 1929 Felty, Augustus R., 50 Farmington Ave.  
 1942 Finesilver, Edward Max, 410 Asylum  
 1934 Finley, George Clark, 50 Farmington Ave.  
 1913 Flaherty, Claude Vincent, 50 Farmington Ave.  
 1943 Fleish, Milton Carl, 64 Garden  
 1943 Fox, George Francis, 1174 Main  
 1931 Friery, Clarence Milton, 110 Greenfield  
 1943 Fritz, John, 656 Park  
 1919 Furniss, Henry Watson, 1337 Main  
 1927 Gaberman, David, 179 Allyn  
 1937 Galinsky, David, 57 Wethersfield Ave.  
 1946 Gardy, Lawrence Andrew, 1731 Park  
 1921 Garland, Robert Bernard, 689 Asylum Ave.  
 1931 Geetter, Isador Stolper, Mt. Sinai Hospital  
 1941 Gibson, Forrest Davis, 701 Asylum Ave.  
 1946 Giffin, Lewis Albee, 179 Allyn  
 1898 Gill, Michael Henry, 36 Pearl  
 1941 Gillespie, Harry, 983 Main  
 1922 Gills, William Lee, 179 Allyn  
 1934 Giorgio, Nicholas Anthony, 61 Edwards  
 1937 Giuliano, Sebastian, 468 Franklin Ave.  
 1935 Glass, George Courtenay, 576 Farmington Ave.  
 1943 Glass, William Henry, 11 Asylum  
 1934 Glaubman, Henry Mitchell, 20 Lenox  
 1946 Godfrey, Ellwood Watson, 179 Allyn  
 1927 Goff, Charles Weer, 30 Farmington Ave.  
 1936 Gold, Louis Henry, 184 North Beacon  
 1930 Goldenberg, Jacob Joseph, 832 Albany Ave.  
 1947 Goldstein, Max Richard, 44 Garden  
 1946 Golino, Emanuel Francis, 635 Main  
 1944 Golston, Harry, 750 Main  
 1933 Goodell, Robert Alban, 79 Elm  
 1900 Goodrich, Charles Augustus, 5 Haynes  
 1919 Gosselin, George Adolor, 50 Farmington Ave.  
 1946 Gottesfeld, Benjamin Harvey, 99 Pratt  
 1935 Gould, Max Martin, 434 Main  
 1923 Grau, Leroy Charles, 700 Main  
 1938 Gray, Harry Joshua, 750 Main  
 1924 Griswold, Matthew Hammond, 165 Capitol Ave.  
 1941 Grossman, Walter, 242 Trumbull  
 1921 Grosvenor, Frank Livingston, 700 Main  
 1930 Hall, Llewellyn, 79 Elm  
 1939 Hall, Wendell Charles, 179 Allyn  
 1938 Harris, Louis David, 242 Trumbull  
 1936 Harvey, Daniel Foster, 218 North Beacon  
 1930 Hastings, Louis Pease, 114 Woodland  
 1937 Hazen, Donald Robert, 295 Farmington Ave.  
 1946 Hellijas, Carl Sylvester, 20 South Hudson  
 1931 Hennessy, James Joseph, 50 Farmington Ave.  
 1946 Hepburn, Robert Houghton, 179 Allyn  
 1907 Hepburn, Thomas Norval, 179 Allyn  
 1940 Heublein, Gilbert Whipple, 179 Allyn  
 1930 Heyman, Joseph, 410 Asylum  
 1934 Hirschfeld, Otto Max, 1037 Albany Ave.  
 1931 Hirshberg, Manuel Shelton, 135 Blue Hills Ave.  
 1925 Hoffman, Charles Curtis, 700 Main  
 1924 Hogan, Walter Louis, 750 Main  
 1929 Holt, Kerchival Rogers, 50 Farmington Ave.  
 1930 Holtz, Raymond Sidney, 7 Woodland  
 1945 Hopper, Jerome Murray, 50 Farmington Ave.  
 1946 Horowitz, Isaac, 95 Pearl  
 1935 Hough, Perry Tyler, 178 Beacon  
 1922 Howe, Glover Elbridge, 576 Farmington Ave.  
 1936 Hurwitz, George Hillel, 99 Pratt  
 1917 Hutchison, James Elder, 665 Asylum Ave.  
 1937 Irving, James Grant, 151 Farmington Ave.  
 1939 Jackson, Allen Francis, 2137 Main  
 1944 Jacobson, Charles Edward, Jr., 50 Farmington Ave.  
 1934 James, Lewis Paul, 11 Asylum  
 1941 January, Derick Algernon, 179 Allyn  
 1942 January, Mildred Hartshorn, 111 Gillett  
 1912 Jarvis, Henry Gildersleeve, 179 Allyn  
 1940 Jenovese, Joseph Francis, 179 Allyn  
 1941 Johnson, Paul, 179 Allyn  
 1930 Jones, Frank Stafford, 179 Allyn  
 1928 Kalin, Jacob Isaac, 725 Asylum Ave.



- 1933 Kardys, John Albert, 487 Main  
 1935 Karotkin, Robert Harold, 816 Albany Ave.  
 1945 Karpe, Richard, 801 Farmington Ave.  
 1935 Kaschmann, Joseph, 42 Asylum  
 1937 Katz, Dewey, 99 Pratt  
 1924 Katz, Henry, 750 Main  
 1941 Katzman, Samuel Sidney, 11 Asylum  
 1926 Keefe, George Gregory, 30 Sisson Ave.  
 1934 Keefe, Raymond Starkey, 272 Franklin Ave.  
 1934 Keefe, Walter Joseph, 30 Sisson Ave.  
 1908 Keith, Albert Russell, 50 Farmington Ave.  
 1920 Kelly, Claude Currie, 179 Allyn  
 1930 Kendall, Ralph Emerson, 20 South Hudson  
 1947 Kenney, William Edmond, 30 Farmington Ave.  
 1927 Kilbourn, Austin, 1039 Asylum Ave.  
 1920 Kilbourn, Joseph Birney, 36 Pearl  
 1906 Kingsbury, Isaac William, 30 Farmington Ave.  
 1946 Kirsch, Neville, 56 Garden  
 1932 Klein, Abraham Arthur, 509 Farmington Ave.  
 1946 Klein, Joseph, 80 Farmington Ave.  
 1925 Knowlton, Millard, 193 Trumbull  
 1944 Krall, Irving Hadley, 99 Pratt  
 1930 Kunkel, Frederick Earle, 179 Allyn  
 1941 Lamoureux, Eugene Edward 165 Capitol Ave.  
 1901 Lampson, Edward Rutledge, 175 North Beacon  
 1938 Lampson, Rutledge Starr, 179 Allyn  
 1913 Landry, Arthur Bernard, 50 Farmington Ave.  
 1926 Landry, Benedict Bernard, 50 Farmington Ave.  
 1940 Lankin, Joseph John, 525 Main  
 1943 Lapenta, Rocco George, 1307 Albany Ave.  
 1929 Larrabee, John Whitfield, 64 Garden  
 1946 Larson, Albert Lloyd, 700 Main  
 1942 Lenehan, John Richard, 683 Asylum Ave.  
 1938 Leonard, John Charles, 20 South Hudson  
 1933 Levin, Albert Eliot, 242 Trumbull  
 1942 Levin, Charles Alec, 854 Asylum Ave.  
 1946 Levin, Robert Raphael, 99 Pratt  
 1935 Levine, Sinclair Simcha, 54 Church  
 1936 Lewis, Samuel Donald, 49 Pearl  
 1937 Lischner, Moses David, 75 Pearl  
 1946 Litter, Leo, 747 Asylum Ave.  
 1934 Little, Milton Frederick, 49 Pearl  
 1915 Locke, Harry Leslie Franklin, 179 Allyn  
 1941 Lowell, William Holbrook, Jr., 703 Asylum Ave.  
 1923 Luby, Thomas John, 410 Asylum  
 1913 Madden, Leon Irving, 234 North Beacon  
 1919 Maislen, Samuel, 2138 Main  
 1931 Mancoll, Morris Max, 242 Trumbull  
 1943 Marinaro, Nicholas Anthony, Cedarcrest  
 1932 Marranzini, Samuel, 763 Albany Ave.  
 1946 Martin, Stevens John, 114 Woodland  
 1930 McClellan, Wilbert Ernest, 75 Pearl  
 1936 McCormack, Christopher Joseph, 50 Farmington Ave.  
 1938 McCrann, Donald Joseph, 50 Farmington Ave.  
 1934 McDermott, John Francis, 750 Main  
 1933 McGrath, John Francis, 663 Maple Ave.  
 1934 McLean, John Joseph, 64 Garden  
 1932 McLellan, Philip Garretson, 297 Farmington Ave.  
 1935 McNulty, Terence Francis, 21 Sisson Ave.  
 1933 Middlebrook, Louis Francis, Jr., 293 Farmington Ave.  
 1937 Miller, Harry Bernard, 983 Main  
 1916 Miller, James Raglan, 179 Allyn  
 1933 Mirabile, Charles Samuel, 179 Allyn  
 1947 Moher, James J., 689 Asylum Ave.  
 1944 Moise, Theodore Sidney, 151 Farmington Ave.  
 1938 Montano, Charles Carl, 525 Main  
 1937 Montano, Rocco Anthony, 42 Yale  
 1909 Morrissey, Michael Joseph, 18 Asylum  
 1929 Morse, Lyman Rogers, Cedarcrest  
 1927 Moylan, Thomas Patrick, 50 Farmington Ave.  
 1930 Moyle, Henry Brown, 79 Farmington Ave.  
 1941 Mozzer, Alexander John, 95 Pearl  
 1942 Mulville, Maurice Francis, 689 Asylum Ave.  
 1897 Naylor, James Henry, 1 Main  
 1938 Neidlinger, William James, 576 Farmington Ave.  
 1946 Nichols, Edward, 576 Farmington Ave.  
 1944 Nyboer, Jan, 140 Garden  
 1944 O'Connell, John Daniel, 50 Farmington Ave.  
 1923 O'Connell, John Francis, 865 Park  
 1928 O'Connell, Maurice Francis, 50 Farmington Ave.  
 1902 O'Flaherty, Ellen Pembroke, 140 Main  
 1928 Ogden, Ralph Trafton, 179 Allyn  
 1931 Olmstead, John Gerald Maurice, 404 Farmington Ave.  
 1937 O'Neil, Charles William, 18 Asylum  
 1921 Osborn, Stanley Hart, 165 Capitol Ave.  
 1927 Osmond, Robert Hunter, 50 Farmington Ave.  
 1938 Padula, Vincent Domenica, 1210 Broad  
 1945 Paladino, Joseph Salvatore, 300 Franklin Ave.  
 1919 Parker, John Woodcock, 84 Forest  
 1926 Partridge, Winthrop Prescott, 247 South Whitney  
 1938 Peacock, Albert Upham, 576 Farmington Ave.  
 1933 Phelps, Maxwell Overlock, 576 Farmington Ave.  
 1937 Phelps, Paul Stetson, State Tuberculosis Commission,  
 119 Ann  
 1929 Pike, Maurice Mitchell, 64 Garden  
 1944 Pitegoff, Gerald Irving, 242 Trumbull  
 1943 Preston, Thomas Raymond, 133 North Quaker Lane  
 1934 Priddy, Foster Eugene, 80 Farmington Ave.  
 1936 Quarrier, Sidney Sayre, 576 Farmington Ave.  
 1923 Radin, Morris Jacob, 36 Pearl  
 1928 Radom, Myron Michael, 242 Trumbull  
 1923 Rankin, Bertrand Fred, 57 Pratt  
 1913 Reardon, William Francis, 750 Main  
 1934 Reidy, David Dillon, 750 Main  
 1928 Reynolds, Harry St. Clair, 410 Asylum  
 1916 Reynolds, Harry Stephen, 18 Asylum  
 1930 Reynolds, Robert Gardner, 179 Allyn  
 1922 Roberts, Douglas James, 179 Allyn  
 1932 Robinson, Albert James, 55 Elm  
 1943 Rocco, Mario P., 1125 New Britain Ave.  
 1940 Roche, Arthur F., 50 Farmington Ave.  
 1934 Rollins, Henry Brock, 140 Garden  
 1909 Rooney, James Francis, 410 Asylum  
 1936 Rosenbaum, George Jonas, 647 New Britain Ave.  
 1938 Rosenthal, Ernest, 18 Asylum  
 1935 Roth, Frank Edward, 179 Allyn  
 1907 Rowley, Robert Lee, 79 Elm  
 1946 Rubin, Albert, 242 Trumbull  
 1921 Russell, George Gardiner, 179 Allyn  
 1936 Ryan, Francis James, 95 Pearl  
 1945 Sachs, Benjamin, 99 Main  
 1923 St. John, Leopold Albert, 25 Charter Oak Ave  
 1926 Salvin, Benjamin Lloyd, 242 Trumbull  
 1937 Sayers, John Joseph, 33 Montford  
 1928 Scafarello, Peter Joseph, 410 Asylum  
 1932 Schaefer, Abraham Maurice, 262 Maple Ave.  
 1934 Schuman, David Harold, 909 Albany Ave.  
 1946 Schwartz, Herbert Norman, 99 Pratt  
 1940 Scoville, William Beecher, 179 Allyn  
 1932 Seibert, Alfred Frank, 700 Main  
 1945 Seidman, Roy Milne, 1179 Main  
 1942 Serbin, Aaron Frederick, 99 Pratt  
 1928 Shaw, George Hammil, 700 Main  
 1920 Shea, Daniel Edward, 137 North Whitney

- 1944 Shepard, Marguerite Dunbar, Cedarcrest  
 1941 Shull, John Coulter, 179 Allyn  
 1933 Shulman, David Nathaniel, 422 Farmington Ave.  
 1932 Sigal, Jacob Bernard, 99 Pratt  
 1940 Silver, Gershon Benjamin, 345 Garden  
 1936 Slossburg, David Seymour, 541 Park  
 1945 Smith, Charles Leonard, 179 Allyn  
 1944 Smith, Percy Lawson, 200 Retreat Ave.  
 1927 Smith, William Bowers, 80 Farmington Ave.  
 1944 Smith, William Leslie, 179 Allyn  
 1939 Smith, Wilson Fitch, 576 Farmington Ave.  
 1937 Sneiderman, George Irving, 322 Vine  
 1929 Snelling, Pinckney Welch, 56 Garden  
 1947 Sohler, Theodore Paul, 805 Main  
 1946 Soifer, Irvin T., 199 Branford  
 1937 Spekter, Louis, 436 Capitol Ave.  
 1921 Spillane, Bernard, 30 Farmington Ave.  
 1941 Sponzo, James Joseph, 3 Webster  
 1927 Standish, Erland Myles, 179 Allyn  
 1897 Standish, James Herbert, 30 Farmington Ave.  
 1931 Standish, Welles Adams, 30 Farmington Ave.  
 1905 Starr, Robert Sythoff, 179 Allyn  
 1946 Steege, Theodore Walter, 179 Allyn  
 1930 Steincrohn, Peter Joseph, 705 Asylum Ave.  
 1930 Stephenson, Charles Wattles, 20 South Hudson  
 1923 Storrs, Ralph Warren, 179 Allyn  
 1907 Swan, Horace Cheney, Trinity College  
 1914 Sweet, John Henry Throop, Jr., 179 Allyn  
 1932 Talbot, Henry Pierce, 165 Capitol Ave.  
 1930 Taylor, Andrew, 179 Allyn  
 1939 Tennant, Robert, 20 South Hudson  
 1922 Thompson, Hartwell Greene, 179 Allyn  
 1938 Tonken, Louis Clarence, 487 Farmington Ave.  
 1938 Tovell, Ralph Moore, 20 South Hudson  
 1930 Townsend, Wilmot Charles, 301 Farmington Ave.  
 1912 Truex, Edward Hamilton, 99 Pratt  
 1942 Truex, Edward Hamilton, Jr., 99 Pratt  
 1908 Tuch, Morris, 99 Pratt  
 1946 Tucker, Charles Albert, 56 Garden  
 1907 Turbert, Edward Joseph, 703 Asylum Ave.  
 1937 Twaddle, Paul Holmes, 576 Farmington Ave.  
 1937 Unsworth, Arthur Charles, 179 Allyn  
 1933 Uricchio, Joseph George, 260 Wethersfield Ave.  
 1908 Vail, George Francis, 36 Pearl  
 1923 VanKleeck, Euen, 700 Main  
 1904 VanStrander, William Harold, 945 Asylum Ave.  
 1926 VanWart, William Haley, 650 Main  
 1917 Vernlund, Carl Frithiof, 179 Allyn  
 1921 Vershbow, Nathan, 28 Sisson Ave.  
 1940 Walker, Robert, 703 Asylum Ave.  
 1932 Wallace, Charles Kenneth, 700 Main  
 1932 Warring, Howard Lewis, 1756 Main  
 1946 Wawro, Nestor William, 179 Allyn  
 1934 Weiner, Julius Gills, 750 Main  
 1943 Weiner, Sylvia, 242 Trumbull  
 1931 Weisenfeld, Nathan, 608 Blue Hills Ave.  
 1936 Weissenborn, Walter, 50 Farmington Ave.  
 1920 Weld, Stanley Burnham, 179 Allyn  
 1916 Wells, Donald Breckinridge, 580 Asylum  
 1943 Wells, Elizabeth C., 436 Capitol Ave.  
 1924 Whalen, Edward Joseph, 750 Main  
 1938 Whitcomb, Benjamin Bradford, 179 Allyn  
 1938 White, Benjamin Vroom, 701 Asylum Ave.  
 1946 White, Edward Philip, 689 Asylum Ave.  
 1942 Whiting, Richard Charles, 700 Main  
 1933 Whitty, Charles Aloysius, Cedarcrest  
 1907 Wiedman, Otto George, 179 Allyn  
 1931 Wienski, John Casimer, 502 Park  
 1946 Wills, Arthur Allison, Jr., 700 Main  
 1943 Wilson, Archibald Cameron, 55 Elm  
 1930 Wilson, William Augustus, 841 Asylum Ave.  
 1941 Wineck, Morris Samuel, 179 Allyn  
 1934 Winters, John Thomas, 957 Farmington Ave.  
 1904 Witter, Orin Russell, 179 Allyn  
 1933 Wood, Frank Oliver, 576 Farmington Ave.  
 1934 Woodford, Chester North, 703 Asylum Ave.  
 1916 Worthen, Thacher Washburn, 179 Allyn  
 1922 Wright, William Witter, 700 Main  
 1932 Wulp, George Adolf, 50 Farmington Ave.  
 1912 Yergason, Robert Moseley, 50 Farmington Ave.  
 1938 Young, William Greenhill, 200 Retreat Ave.  
 1928 Zariphes, Constantine Argyros Paleslogos, 96 Main  
 1947 Zarkin, Oscar Howard, 99 Pratt  
 1934 Zeman, Burnhardt, 983 Main  
 1946 Zeman, Michael Saxe, 179 Allyn

## MANCHESTER

- 1937 Barry, Joseph Charles, 156 Main  
 1946 Besser, Edward Lambert, 11 Oak  
 1924 Boyd, Howard, 935 Main  
 1939 Conlon, William Linas, 33 Main  
 1940 Diskan, Albert Elmer, 869 Main  
 1936 Keeney, Robert Raymond, Jr., 75 Robert Rd.  
 1925 Knapp, Robert Phineas, 146 Hartford Rd.  
 1946 Lechause, Ralph M., 470 Main  
 1946 Massaro, Joseph, 29 Park  
 1946 Miller, Gerard Roland, 755 Main  
 1916 Moore, Demarquis, DeCasso Ye Rujo, 63 Benton  
 1945 Peckham, Charles Henry, 875 Main  
 1945 Prignano, John Vincent, 5 Middle Turnpike, West  
 1947 Rosen, Theodore, 829 Main  
 1941 Segal, Jacob A., 889 Main  
 1937 Sundquist, Alfred Bernhardt, 11 Oak  
 1946 Watson, Robert Webster, 183 East Center  
 1943 Yerbury, Charles Calvin, 829 Main  
 1936 Zaglio, Edmond Robert, 12 Myrtle

## SOUTH MANCHESTER

- 1926 Caldwell, David Manchester, 935 Main  
 1926 Friend, Amos Edgar, 935 Main  
 1921 Lundberg, George Albin Ferdinand, 755 Main  
 1930 Moriarty, Mortimer Emmett, 905 Main

## NEW BRITAIN

- 1945 Benjamin, Henry Weston, New Britain General Hospital  
 1932 Benoit, Raoul Joseph, 51 Cedar  
 1934 Bernstein, Dwight J., 300 Main  
 1930 Blogoslawski, Walter Joseph, 199 West Main  
 1935 Bristoll, Donald Andrews, 32 Grove Hill  
 1940 Buccheri, Francis Salvatore, 19 South High  
 1927 Buol, Robert Stanley, 99 West Main  
 1926 Chernaik, Samuel Julius, 300 Main  
 1946 Clark, Bliss Bartlett, 32 Grove Hill  
 1945 Clarke, Harold Metcalfe, 99 West Main  
 1913 Cooley, Clifton Mather, 44 South High  
 1939 Daley, Louis William, 32 Grove Hill  
 1938 Dalton, George Henry, 99 West Main  
 1931 Darrow, John Edward, 55 West Main  
 1928 Donnelly, Stephen Patrick, 55 West Main  
 1941 Dorian, George David, 300 Main  
 1941 Dorian, Neshon Edward, 300 Main  
 1934 Dray, Edward Joseph, 259 Main



- 1915 Dunn, George Washington, 55 West Main  
 1942 Eisenberg, Sidney Edwin, 55 West Main  
 1933 Ellis, Francis Duffy, Jr., 45 Cedar  
 1947 Elsberg, Charles Palmer, 235 West Main  
 1936 Enander, Fred Conrad, 25 Arch  
 1941 Goldschmidt, Myer, 25 Arch  
 1921 Grant, Arthur Sheldon, 55 West Main  
 1943 Greenblatt, Harold Joseph, 99 West Main  
 1945 Greenstein, Charles Jacob, 300 Main  
 1937 Hart, Carl Jay, 259 Main  
 1930 Kalett, Joseph, 55 West Main  
 1942 Kraszewski, Henry Walter, 308 Main  
 1942 Lacava, John James, 300 Main  
 1946 Larkin, John Charles, New Britain General Hospital  
 1926 Lekston, Roman Francis, 197 West Main  
 1946 Levine, Howard, 81 West Main  
 1938 LoVetere, Angelo Arthur, 29 Park Pl.  
 1930 Matteis, Joseph Theodore, 55 West Main  
 1939 McMahon, George William, 419 Main  
 1946 Mellion, Jacob, Walnut Hill School  
 1934 Michalowski, Valerian Stanislaus, 489 Main  
 1946 Mlynarski, Joseph Andrew, 43 Cedar  
 1935 Moorad, Philip Jacob, 55 West Main  
 1923 Mouradian, Marion Garoudy, 87 Prospect  
 1938 Mucci, Lawrence Adolf, 32 Grove Hill  
 1938 Orbach, Egmont Julius, 81 West Main  
 1939 Paolillo, Charles Gerald, 55 West Main  
 1938 Parlato, Harry Anthony, 242 Main  
 1944 Peck, Bernard Carl, 32 Park Pl.  
 1938 Perakos, George Peter, 300 Main  
 1939 Pola, William Edward, 324 Elm  
 1930 Pullen, Richard Woollard, 55 West Main  
 1936 Resnik, Edward, 272 Main  
 1940 Rosahn, Paul Dolin, New Britain General Hospital  
 1930 Schechtman, Charles Theodore, 81 West Main  
 1931 Schupack, Samuel David, 99 West Main  
 1938 Scully, Roger Tehan, 92 Hart  
 1930 Slys, Ladislaus Bernard, 247 West Main  
 1928 Smith, Vincent Joseph, 55 West Main  
 1936 Squillacote, Vincent Joseph, 55 West Main  
 1938 Sullivan, Charles Noyes, 55 West Main  
 1940 Tisher, Paul Winslow, 99 West Main  
 1935 Tokarczyk, John Joseph, 32 North  
 1941 Trapp, Francis W., 55 West Main  
 1945 Vetrano, Samuel Anthony, 259 Main  
 1928 Waskowitz, David, 81 West Main  
 1934 Watson, William James, 223 West Main  
 1932 White, John Cowles, 32 Grove Hill  
 1941 Wilson, Dwight E., 32 Grove Hill  
 1945 Zwick, Frank, 35 South High

## NEWINGTON

- 1946 Beardsley, Lewis George, Veterans Hospital  
 1942 Freeman, John Jay, 1100 Main  
 1946 Friedberg, Isadore Hirsh, 1078 Main  
 1947 Gurwitz, Jack, Veterans Hospital  
 1946 Hurwitz, Alfred, Veterans Hospital  
 1946 Kunkel, Paul, Veterans Hospital  
 1940 Nevulis, Antony Victor, Newington Home for Crippled Children  
 1946 O'Neil, Vincent Danforth, 26 Walsh Ave.  
 1934 Sills, Theodore Hopkins, 897 Main

## PLAINVILLE

- 1878 Bull, John Norris, 57 Whiting  
 1931 Cook, George Francis, 4 East Main  
 1931 Frost, Lawrence Hubbard, 98 West Main

- 1943 Iannotti, John Pasquale, 51 Whiting  
 1934 Menousek, Joseph Albert, 104 Trumbull Ave.  
 1938 Tortolani, Aresto Peter, 75 East Main

## PLANTSVILLE

- 1937 Connor, George Michael, 772 South Main

## ROCKY HILL

- 1940 Kelley, Newell Raymond, 23 Riverview Rd.  
 1904 Moser, Oran Alexander, Elm  
 1946 Walker, Donald Albert, 20 Riverview Rd.

## SIMSBURY

- 1941 Fuller, Roger Holden, Post Office Bldg.  
 1925 Murphy, Owen Lee, Weatogue  
 1939 Murphy, Thomas Denis, c/o O. L. Murphy  
 1932 Stretch, James Edison, Hopmeadow

## SOUTHINGTON

- 1935 Dudac, Thomas William, 9 Center  
 1933 Gura, George Michael, 22 Main  
 1935 Nagle, William Thomas, 23 Woodruff  
 1929 Simmons, Eric Melville, 93 Main  
 1929 Thalberg, Reuben Edward, 32 North Main

## SUFFIELD

- 1938 Coates, Stephen Paul, 328 Main  
 1929 Levy, William, 339 Main  
 1930 Upton, William Hart, 172 Main

## UNIONVILLE

- 1932 Dawson, Lionel Montrose, 94 Perry  
 1937 Dunne, Edward Patrick, Main  
 1941 O'Connell, Enos Joseph, 60 Main

## WEST HARTFORD

- 1913 Biram, James Harrington, 18 Birch Rd.  
 1947 Bowen, Frances Dorsey Thomas, 111 Somerset  
 1903 Brainard, Clifford Brewster, 10 Mountain View Dr.  
 1946 Buchan, Ronald Forbes, 57 Robin Rd.  
 1937 Burns, Maudie Marie, 30 Sulgrave Rd.  
 1947 Campbell, Robert Harold, 55 North Main  
 1942 Canby, Joseph Edward, Pratt & Whitney Co.  
 1931 Case, Edward Percy, 28 Brunswick Ave.  
 1932 Crawley, George Andrew, 330 Park Rd.  
 1928 Cushman, Laurence Arnold, 23 South Main  
 1910 Denne, Thomas Harmon, 39 North Main  
 1932 Filson, Ralph Marshall, 54 Crestwood Rd.  
 1926 Glazier, J. Raymond, 26 Sequin Rd.  
 1939 Gray, Albert Stanley, 1271 Farmington Ave.  
 1930 Griggs, John Bolter, 42 Middlefield Dr.  
 1939 Hollinshead, Joseph Bentley, 1064 Farmington Ave.  
 1944 Klein, Rose Herchman, 58 Flagg Rd.  
 1920 Leak, Roy Lathen, 363 Ridgewood Rd.  
 1932 Lundborg, Francis Ludwig, 35 North Main  
 1935 Martin, John Garthwaite, 7 South Main  
 1943 McPartland, Charles E., Town Hall  
 1947 Miller, Seymour M., 62 LaSalle Rd.  
 1946 Missett, James Stephen, 62 LaSalle Rd.  
 1935 Murphy, Thomas Francis, 683 Asylum Ave.  
 1930 Parshley, Philip Ford, 818 Farmington Ave.  
 1947 Pierce, Harold Fisher, 156 Raymond Rd.  
 1946 Purney, John, Jr., 797 Farmington Ave.  
 1927 Resnisky, Andrew Francis, 75 Bainbridge Rd.  
 1937 Rogers, Frederick Peckham, 11 Ballard Dr.  
 1924 Root, Maurice Timothy, 51 North Main  
 1935 Root, Sophie Andrews, 51 North Main

- 1910 Rowley, John Carter, 205 Girard Ave.  
 1947 Schatten, Siegfried Sylvester, 1157 New Britain  
 1901 Smith, Earl Terry, P. O. Box 42  
 1935 Standish, Hilda Crosby, Greenridge Lane, Sunset Farm  
 1936 Stewart, Lester Quentin, 77 South Main  
 1941 Sullivan, Arthur Bland, 10 North Main  
 1937 Tait, Arthur Alfred, 333 Park Rd.  
 1921 Thenebe, Carl Leonard, 720 Farmington Ave.  
 1937 Walton, Loftus Linwood, 797 Farmington Ave.  
 1942 Wells, Jean, 1018 Farmington Ave.  
 1922 Wentworth, John Alexander, 74 Mohawk Dr.

## ELMWOOD

- 1946 Baskin, Abraham Hyman, 422 New Britain Ave.  
 1946 Calef, Benson, 1157 New Britain Ave.  
 1932 Romaniello, Rocco John, 1086 New Britain Ave.  
 1941 Sewall, Sydney, 1170 New Britain Ave.

## WETHERSFIELD

- 1938 Carvey, Edward Vincent, 1 Garden  
 1933 Howard, Harold Amasa, 330 Main  
 1932 Storms, William Frederick, 147 Main  
 1940 Warren, Henry Stanley, 184 Main

## WINDSOR

- 1930 MacCready, William Harold, 38 Elm  
 1939 Monacella, John Manilla, 22 Elm  
 1924 Pratt, Aaron Paul, 253 Broad

## WINDSOR LOCKS

- 1937 Coyle, Bruce James, 2 Chestnut

## OUT OF COUNTY

- 1942 Brackin, John Tudor, Jr., U.S.V.A. Hospital, Hines, Ill.  
 1945 Breyer, Amy, 8724 Harding, Houston, Texas  
 1911 Cobb, Albert Edward, Canaan  
 1940 Cogland, John Lee, Genesee Hospital, Rochester, N.Y.  
 1939 Ewell, John Woodruff, 109 College, New Haven  
 1946 Gallo, William Joseph, Veterans Administration, Pass-A-Grille, Florida  
 1925 Gore, Michael Alvord, Box 155, Granby, Colo.  
 1943 Greene, Gerald G., Massachusetts General Hospital, Boston, Mass.  
 1947 Hamlin, Charles Hezekiah, Boston City Hospital, Boston, Mass.  
 1934 Horning, Benjamin Graham, W. W. Kellogg Foundation, Battle Creek  
 1943 Humpage, Norbert W., 19 Mason, Torrington  
 1924 Kinsella, Michael Allen, 320 Monroe St., Hollywood, Florida  
 1928 Mahoney, Daniel F. C., 821 Crescent Ave., Redlands, Calif.  
 1946 Messina, Michael Corinth, Veterans Administration, Bay Pines, Fla.  
 1939 Moyness, Bennie A., U. S. Army  
 1942 O'Brien, Henry Rust, U.S.P.H.S., Washington, D. C.  
 1944 Perkins, Joseph Augustine, McGill University, Montreal, Canada  
 1923 Pendleton, Ernest Raymond, Granville Rd., Westfield, Mass.  
 1939 Phillips, Paul Lange, Dispensary, Norfolk, Va.  
 1947 Plachta, Aaron, 233 West 72nd St., New York City  
 1902 Purinton, Charles Oscar, New Hartford  
 1916 Simonton, Frank Forester, 634 West Cliveden St., Philadelphia, Penn.  
 1942 Smith, Hugh Allen, Eastern Maine General Hospital, Bangor, Maine

- 1944 Solomkin, Mark, Chicago Maternity Hospital, Chicago, Illinois  
 1923 Walker, William Hastings, Newtown  
 1942 Weigle, Luther Alan, Jr., 43 Summit Rd., Newport, N.H.

## Litchfield County Association

*President:* WINFIELD E. WIGHT, 24 Goodwin Court, Thomaston

*Vice-President:* FRANK L. POLITO, 24 Church St., Torrington  
*Secretary-Treasurer:* THOMAS J. DANAHER, 106 Litchfield St., Torrington

*Councilor:* FLOYD A. WEED, 199 Main St., Torrington

Annual Meeting, Fourth Tuesday in April

Semi-Annual Meeting, First Tuesday in October

## CORNWALL

- 1922 Walker, Wilmarth Bradford

## CORNWALL BRIDGE

- 1931 Evarts, Josephine, Warren Rd.

## HARWINTON

- 1906 Griswold, Maude Taylor

## KENT

- 1946 Greiner, George Frederick, Kent School  
 1947 Grendon, David Arthur, Lane

## LITCHFIELD

- 1946 Dautrich, Albert William, South  
 1935 Kilgus, John Frank, Jr., 80 West  
 1910 Turkington, Charles Henry, On-the-Green  
 1939 Warner, Charles Norton, Jr., North  
 1936 Wray, Edward Holloway, Jr., North

## NEW HARTFORD

- 1942 Markwald, Heinz Wolfgang, Steele Rd.

## NEW MILFORD

- 1939 LaTaif, C. George, 20 Bridge  
 1938 Stevens, Howard Granson

## NORFOLK

- 1937 Barstow, Richard Iddings, The Village Green  
 1934 Ursone, Frank Domenico, Greenwood Rd., W.

## NORTH CANAAN

## CANAAN

- 1929 Adam, Forbes Sampson  
 1946 Bornemann, Carl, Main  
 1935 Elliott, John Richard  
 1924 Sellew, Robert Cowan  
 1938 Sellew, Robert Cowan, Jr.

## PLYMOUTH

## TERRYVILLE

- 1913 Lawton, Richard John, 9 North Main  
 1939 Wilcox, Lloyd Mather, 19 Maple

## SALISBURY

- 1945 Brewer, Alfred Edwin  
 1946 Combes, J. DeRaimes



LAKEVILLE

- 1943 Mackay, William D.
- 1923 Peterson, Clark Kimball
- 1936 Wieler, Harry Julius, Hotchkiss School

SHARON

- 1904 Chaffee, Jerome Stuart, Sharon Hospital
- 1942 Gudernatch, Gaert Steuerwald

SOUTH KENT

- 1947 Blaine, Graham Burt, Jr., Bulls Bridge Rd.

THOMASTON

- 1938 Atha, Henry George, 147 Elm
- 1946 Conklin, Clifford T., Jr., 16 Grand
- 1903 Hazen, Robert, 45 Union
- 1910 Kane, James Hugh, 205 South Main
- 1922 Wight, Winfield Emmons, 24 Goodwin Court

TORRINGTON

- 1946 Adams, Arthur John, Charlotte Hungerford Hospital
- 1937 Bienkowski, Joseph George, 24 Church
- 1946 Blinkoff, Jack J., 5 Water
- 1946 Buckley, John Littlefield, 30 Mason
- 1898 Carlin, Charles Henry, 236 Main
- 1946 Chait, Sidney, 40 Main
- 1930 Danaher, Thomas Joseph, 106 Litchfield
- 1938 Dobbs, William G. H., 24 Church
- 1946 Fabro, J. Alfred, 355 Prospect
- 1935 Garston, Louis Edward, 49 Main
- 1931 Giobbe, Michael Edward, 355 Prospect
- 1936 Goldberg, Isadore Solomon, 5 Water
- 1908 Hanchett, Harry Bigelow, 51 Main
- 1936 Hill, Emerson Stanley, 51 Main
- 1941 Hubert, Gilbert Richard, 24 Church
- 1938 Kott, Joseph Henry, 18 Pearl
- 1936 LoRusso, Domenico Leonardo, 40 Main
- 1942 Mitchell, Gerald Vincent, 51 Main
- 1938 Murcko, William John, 497 Main
- 1923 Oelschlegel, Herbert Charles, 355 Prospect
- 1938 Orlowski, Andrew Williams, 19 Mason
- 1923 Polito, Frank Leonard, 24 Church
- 1942 Riendeau, Fernand Maurice, 30 Mason
- 1942 Riendeau, Pauline Laure, 30 Mason
- 1932 Samponaro, Nicholas, 201 Calhoun
- 1940 Shupis, Anthony, Jr., 60 Main
- 1936 Sutherland, Francis Alexander, 24 Mason
- 1917 Thomson, Thomas Leonard, 24 Mason
- 1898 Wadhams, Sanford Hosea, 908 Main
- 1942 Wallach, Gert M. K., 91 Church
- 1917 Weed, Floyd Albert, 199 Main

WASHINGTON

- 1927 Jackson, Arthur Hartt
- 1946 Simonds, John Rolf
- 1908 Wersebe, Frederic William

WASHINGTON DEPOT

- 1946 Bader, George Bernard

WATERTOWN

- 1946 Caney, Wilbur Hinds, 429 Main
- 1936 Cleary, Harold John, Main
- 1946 Louderbough, Henry, 313 Main
- 1897 Loveland, Ernest Kilborn, 48 North
- 1922 Martin, James Smith
- 1936 Meyers, Royal Abbott, 162 Main
- 1919 Reade, Edwin Godwin, 429 Main

WINCHESTER

WINSTED

- 1945 Ashley, Homer Champion, 384 Main
- 1938 Baker, Philip George, 26 Elm
- 1936 Cornelio, Francis Joseph, 153 Main
- 1915 English, Chester Ferrin, 64 Main
- 1945 Funkhouser, Selmes Paul, 26 Elm
- 1937 Gallo, Francis, 384 Main
- 1927 Herman, Donald Warner, 486 Main
- 1936 Levy, Aaron, 504 Main
- 1947 Reidy, Joseph Carey, 350 Main
- 1922 Sanderson, Roy Voter, 518 Main

WOODBURY

- 1944 Gillette, Arthur Taylor, Main

OUT OF COUNTY

- 1921 Childs, Albert Ewing, Stanfield, Oregon
- 1942 Downs, Elinor Fosdick, 4 The High Rd., Bronxville, New York
- 1917 Kennedy, William Clement, 120 Dwight, New Haven
- 1940 Markle, Raymond Dunsmore, 53 Cooke, Waterbury
- 1881 Platt, William Logan, State Hospital, Newtown
- 1887 Pratt, Elias 33 West Ave., Essex

Middlesex County Association

*President:* FRANK H. COUCH, Cromwell Hall, Cromwell  
*Vice-President:* PHILIP E. SCHWARTZ, 309 Main, Portland  
*Secretary:* NORMAN E. GISSLER, 164 Court, Middletown  
*Councilor:* HAROLD E. SPEIGHT, 70 Crescent, Middletown

Annual Meeting, Second Thursday in April  
 Semi-Annual Meeting, Second Thursday in October

CHESTER

- 1941 Callender, Eugene Frederick, Drawer F
- 1942 Owen, Philip Stanley, Parker's Pt.

CLINTON

- 1937 Rindge, Norman Pember, 20 Commerce
- 1935 Stone, Harry Russell, 67 West Main

CROMWELL

- 1934 Couch, Frank Hallock, Cromwell Hall
- 1934 Couch, Mildred Warden, Cromwell Hall
- 1940 Grant, Richard Francis, 221 Main
- 1928 Nelson, Walter Nathaniel, 76 Main
- 1925 Pierson, Emily Miller, 107 Main

EAST HADDAM

- 1935 Horsefield, Thomas Earl, P. O. Box 40

EAST HAMPTON

- 1921 Felt, Paul Revere, R. F. D. No. 1
- 1936 Gardner, Norman Homer
- 1934 Soreff, Louis, 15 Main

ESSEX

- 1942 Ames, William Gard
- 1903 Bradeen, Frederick Barton, P. O. Box No. 221
- 1946 Scott, James Clifford

HIGGANUM

- 1937 Calhoun, Hazen Albert, Jr.

## MIDDLEFIELD

- 1947 Smith, Harold Ellsworth

## MIDDLETOWN

- 1942 Alexander, Stanley Joseph, 516 Main  
 1933 Beauchemin, Joseph Adelard, Connecticut State Hospital  
 1941 Buckley, Willard Emrich, Middlesex Hospital  
 1926 Chase, Carl Clarence, 121 Main  
 1928 Compson, Florence Eberly Mentzer, Connecticut State Hospital  
 1924 Craig, George Mansfield, 119 Main  
 1942 Crampton, Clair Beebe, 119 Main  
 1946 DeTora, Albert Michael, 612 Main  
 1933 Fekety, Stephen Henry, 675 Main  
 1900 Fisher, Jessie Weston, 28 Crescent  
 1927 Frank, Harry Selig, 144 Washington  
 1931 Gissler, Norman Edwin, 164 Court  
 1927 Grower, Julius Harry, 164 Court  
 1920 Harvey, Carl Clifford, 119 Main  
 1924 Joyce, William Michael, 121 Main  
 1946 Knight, Harry Charles, 33 Pleasant  
 1928 LaBella, Louis Oronato, 612 Main  
 1935 Lieberman, David Leonard, Central National Bank Bldg.  
 1942 Lindsay, Marie Strom, Connecticut State Hospital  
 1925 Loffredo, Louis, 77 Crescent  
 1929 Magnano, Joseph, 100 Broad  
 1940 McLeod, Christie Ellen, 28 Crescent  
 1934 Minor, Lloyd Wesley, 119 Main  
 1896 Murphy, James, 101 Broad  
 1939 Palmieri, Mario Lorenzo, 54 Broad  
 1928 Piasta, Peter Ferdinand, 145 South Main  
 1946 Pilecki, Peter John, 468 Main  
 1943 Rakkind, Abraham Benjamin, 108 Main  
 1934 Roccapriore, Benjamin Anthony, 287 Washington Ter.  
 1926 Russman, Charles, Connecticut State Hospital  
 1945 Shenker, Benjamin Morton, 250 Main  
 1940 Sherwood, Henry, 516 Main  
 1942 Simon, Benjamin, Connecticut State Hospital  
 1929 Speight, Harold Edmund, 70 Crescent  
 1946 Sutch, Gabriel Charles, Connecticut State Hospital  
 1924 Sweet, Alfred Norton, 164 Court  
 1946 Thumim, Mark, 121 Main  
 1933 Tracy, Frederick Erwin, 164 Court  
 1919 Van Cor, Chester Arthur, 14 Walnut  
 1942 Vinci, Vincent John, 70 Crescent  
 1934 Waterman, Chester, 119 Main  
 1933 Whiting, Harry St. John, Connecticut State Hospital  
 1925 Wilder, Ella Annis, 80 South Main  
 1943 Wilk, Edward Kennard, Connecticut State Hospital  
 1922 Wrang, William Emil, 296 Main  
 1944 Yerbury, Edgar C., Connecticut State Hospital

## MOODUS

- 1946 Berwick, Philip

## OLD SAYBROOK

- 1941 Deming, Nelson Lloyd  
 1905 Granniss, Irwin, P. O. Box 312  
 1934 Greenberg, Aaron, Main  
 1946 Saunders, George Robert, P. O. Box 92

## PORTLAND

- 1947 Longo, Americo Domenico, 344 Main  
 1938 Prout, Edgar Bacon, 48 Bartlett  
 1941 Ryan, V. Gerard, 25 Marlborough  
 1933 Schwartz, Philip Edward, 309 Main

## SAYBROOK

## DEEP RIVER

- 1939 Lobb, Russell Albert, 131 Main  
 1903 Pratt, Arthur Milton, P. O. Box 477  
 1932 Tate, William James, Elm

## OUT OF COUNTY

- 1944 Bixby, Harriet, Quain & Ramstad Clinic, Bismarck, N.D.  
 1937 Geck, Otto Francis, 95 Pearl St., Hartford  
 1924 Holley, Erving, Brattleboro Retreat, Brattleboro, Vermont  
 1944 Katzenstein, Rolf Ewald, Meriden Hospital, Meriden  
 1904 Kingman, James Henry, 96 Everit, New Haven

## New Haven County Association

*President:* RALPH E. McDONNELL, 158 Whitney Ave., New Haven

*Vice-President:* SAMUEL B. RENTSCH, 61 Seymour Ave., Derby

*Secretary:* COURTNEY C. BISHOP, 33 Whitney Ave., New Haven

*Councilor:* HERBERT THOMS, 789 Howard Ave., New Haven

Annual Meeting, Fourth Thursday in April

Semi-Annual Meeting, Fourth Thursday in October

## ANSONIA

- 1916 Aaronson, Michael S., 190 Main  
 1937 Alu, Anthony F., 290 Main  
 1935 Blumenthal, Edward Jedediah, 88 Main  
 1938 Casagrande, John Joseph, 178 Main  
 1946 Galin, Jack Harris, 261 Main  
 1946 Haddad, Fred Melad, 156 Main  
 1943 Lencz, Erwin D., 50 Main  
 1907 Parmelee, Edward Kibbe, 50 Main  
 1932 Renahan, John Michael, 100 Main  
 1924 Senfield, Maxon Major, 110 Main  
 1947 Sivak, George C., 312 Main

## BRANFORD

- 1934 Blanchard, Dana Lincoln, 87 Main  
 1940 Carpinella, Michael Joseph, 48 Kirkham  
 1917 Gaylord, Charles William, 93 South Main  
 1929 Levy, Nathan, 140 Montowese  
 1916 McQueen, Arthur Samuel, 187 Montowese  
 1947 Riesman, John Penrose, R. F. D. No. 2  
 1946 Rosenthal, Richard Louis, 55 South Main

## PINE ORCHARD

- 1919 Smith, George Milton

## CHESHIRE

- 1911 Herr, Edward Albert, Main  
 1923 Moore, Wilbur John, Maple Ave.  
 1940 Neff, William Everett, Jr., Main  
 1939 Oxnard, Edward Warren, Maple Ave.

## DERBY

- 1927 Burns, George Dewey, 42 Seymour Ave.  
 1941 D'Alessio, Charles Magno, 272 Main  
 1940 D'Ambruso, Dominic Charles, 46 Atwater  
 1944 Davis, Donald Alan, 38 Elizabeth  
 1940 Dreher, Samuel Meyers, 282 Main  
 1938 Ignace, Stephen James, 12 Elizabeth  
 1944 Narowski, John Joseph, 47 Seymour Ave.  
 1910 Parlato, Michael Antonio, 270 Elizabeth  
 1925 Rentsch, Samuel Burton, 61 Seymour Ave.  
 1940 Stygar, Joseph Stanislaus, 272 Main  
 1910 Treat, William Howard, 166 Minerva



EAST HAVEN

- 1940 Balletto, Vincent, 535 Thompson Ave.
- 1937 Beckwith, Donald MacFarlane, 239 Main
- 1940 Grenon, Ovilla Arzidas, 265 Main
- 1924 Taylor, Robert Mitchell, 578 Thompson Ave.

GUILFORD

- 1941 McGuire, Frank James, 29 Whitfield
- 1916 Smith, Frederic DeWitt, 55 Park

HAMDEN

- 1947 Carbone, William Charles, 1428 Dixwell Ave.
- 1936 Corey, Walter Van Arsdale, 1188 Whitney Ave.
- 1943 Elkinton, Joseph Russell, 105 Clifford
- 1926 Ematrudo, Frederick Roys, 1756 Whitney Ave.
- 1944 Fischer, Alexander, 1324 Dixwell Ave.
- 1942 Gilmore, Helen Richter, 188 Grandview Ave.
- 1943 James, George R., 25 Central Ave.
- 1942 McKeon, James Joseph, 1828 Dixwell Ave.
- 1916 Morse, Arthur Henry, 141 Deepwood Dr.
- 1938 Parente, Leonard, 126 Church
- 1946 Slater, Daniel, 1100 Dixwell Ave.
- 1927 Slater, Morris, 1100 Dixwell Ave.

MADISON

- 1946 Birnbaum, Hyman Bunge
- 1942 Hughson, Frances Gramling, Boston Post Rd.
- 1943 Rindge, Mila Elisabeth, Boston Post Rd.
- 1908 Rindge, Milo Pember, Boston Post Rd.
- 1946 Spencer, Susan Benedict, Island Ave.

MERIDEN

- 1934 Affinito, Thomas, 128 West Main
- 1946 Boguniecki, Stanley Joseph, 118 Colony
- 1945 Brown, Marion R. Snyder, 3 Colony
- 1928 Caplan, Henry, 219 West Main
- 1939 Caplan, Max, 197 Cooke Ave.
- 1937 Carey, William Clark, 61 Colony
- 1946 Clarke, Winthrop Irving, 43 1/2 Colony
- 1937 Cohen, David Jerome, 3 Colony
- 1926 Conroy, Michael Joseph, 64 1/2 East Main
- 1939 de La Vergne, Paul Mason, Undercliff
- 1927 DeRosa, Sylvester Frank, 29 Cook Ave.
- 1946 DiGiandomenico, Albert Theodore, 63 Yale
- 1930 Foster, Edward Wendell, 147 West Main
- 1940 Fox, George Graham, 147 West Main
- 1921 Gibson, Cole Blease, Undercliff
- 1946 Gillings, James Curtis, 69 East Main
- 1947 Giuffrida, Francis, 31 Wall
- 1946 Glike, Frederick Philip, 99 Colony
- 1929 Hall, William Edward, 147 West Main
- 1946 Huss, John Henry, 118 Colony
- 1941 Katz, Irving, 42 1/2 East Main
- 1944 Krochmal, Heinrich, 455 Broad
- 1939 L'Heureux, Jerome Arthur, 455 Broad
- 1934 Lirot, Stephen Leo Robert, 147 West Main
- 1907 Lockwood, Howard DeForest, 248 East Main
- 1946 Lohrmann, Walter, Undercliff
- 1934 Mekrut, Joseph Anthony, 68 East Main
- 1928 Mills, Bernard Litchfield, 94 East Main
- 1934 Misuk, Joseph Francis, 428 Broad
- 1913 Murdock, Thomas Patrick, 147 West Main
- 1921 Otis, Fessenden Newport, 165 West Main
- 1920 Otis, Israel Sabine, 165 West Main
- 1932 Pennington, Harry Freeman, 455 Broad
- 1931 Pierson, Louis A., 199 West Main
- 1916 Quinlan, Raymond Vincent, 5 State

- 1947 Robb, Samuel Aloysius, 69 East Main
- 1944 Ryan, Allan James, 147 West Main
- 1913 Smith, David Parker, 199 West Main
- 1942 Smith, Edward Rice, 199 West Main
- 1935 Solomon, Charles Isadore, 147 West Main
- 1943 Solomon, Rebecca Zinsher, 294 Colony
- 1934 Strickland, Harold, 128 West Main
- 1945 Taylor, Hoyt Chase, 199 West Main
- 1931 Thompson, Lawrence Everett, Undercliff
- 1921 Tower, Arthur Augustus, 147 West Main
- 1940 Van Leuvan, James Sipple, 61 Colony
- 1946 White, Howard Thomas, Undercliff
- 1921 Wilson, James Alfred, 61 Colony

MILFORD

- 1938 Barney, Walter Edward, 186 Broad
- 1942 Davis, George Breed, Milford Health Department
- 1913 Fischer, William John Henry, 3 Lafayette
- 1929 Geib, Henry Albert, Zion Hill Rd.
- 1946 Higgins, Harold Gerard, 64 West River
- 1946 Keating, George Adelbert, 50 Green
- 1944 Langner, Helen P., 1 Shipyard Lane
- 1939 Lee, Frank Nelson, 56 Broad
- 1946 Lipkoff, Clarence Joseph, 7 River
- 1947 Malone, Robert Francis, 157 Gulf
- 1946 Marinoff, Philip A., 56 Broad
- 1946 Rosenthal, Benjamin B., 26 Lafayette
- 1946 Stein, Julius Daniel, 278 Gulf
- 1941 Stetson, Charles Greaves, 114 Broad
- 1933 Stetson, Harry Warren, 114 Broad
- 1946 Timm, Alexander Berthold, Jr., 36 West Main
- 1940 Viola, Carl Philip, 26 Cherry

DEVON

- 1934 Andrus, Oliver Burton, 32 Daytona Ave.
- 1941 Lee, John Ranks, 21 Colonial

NAUGATUCK

- 1941 Bluestone, David Harrison, 9 Terrace Ave.
- 1922 Duffy, Vincent Paul, 83 Meadow
- 1923 Hill, William Edward, 150 Meadow
- 1940 Kennedy, Charles Stephen, 14 Hillside Ave.
- 1938 Reilly, Walter John, 170 Meadow
- 1937 Towne, Nehemiah Alvarado, 297 Church
- 1940 Tylec, Leo Louis, 156 Meadow
- 1944 Weile, Fred William, 270 Church
- 1926 Williams, Edward Everett, 269 Church

NEW HAVEN

- 1941 Aiello, Louis James, 251 Edwards
- 1921 Alderman, Irving Saunders, 204 Park
- 1925 Allen, Edward Pratt, 265 Church
- 1941 Allen, John Clinton, 262 Bradley
- 1902 Allen, Millard Filmore, 65 Dixwell Ave.
- 1946 Alley, Ralph David, 789 Howard Ave.
- 1893 Alling, Arthur Nathaniel, 257 Church
- 1947 Allinson, Morris Jonathan Carl, 1033 Dixwell Ave.
- 1932 Amatruda, Frank Gabriel, 542 Chapel
- 1930 Arnold, Hermann Bruno, 1442 Chapel
- 1945 Arrick, Myron S., 934 Elm
- 1920 Barker, Creighton, 258 Church
- 1908 Barrett, William Joseph, 265 Church
- 1896 Bartlett, Charles Joseph, 183 Bishop
- 1936 Bassin, Alexander Lewis, 255 Bradley
- 1930 Batelli, Clement Francis, 161 Church
- 1925 Battista, Anthony William, 111 Osborn Ave.
- 1947 Beauchamp, Maurice Flavian, Grace Hospital

- 1909 Beck, Frederick George, 193 York  
 1926 Behan, Edmund Joseph, 1370 Chapel  
 1931 Benedict, Mary Kendrick, 291 Whitney Ave.  
 1940 Berlowe, Max Llewellyn, 315 Whitney Ave.  
 1920 Berman, Harry Loring, 1142 Chapel  
 1944 Berneike, Robert R., 789 Howard Ave.  
 1940 Biondi, Benedict, 120 Blatchley Ave.  
 1939 Bishop, Courtney Craig, 33 Whitney Ave.  
 1907 Blake, Eugene Maurice, 303 Whitney Ave.  
 1922 Blake, Francis Gilman, 789 Howard Ave.  
 1927 Blodinger, Israel Edward, 291 Whitney Ave.  
 1911 Boardman, Albertus Kellogg, 441 Forbes Ave.  
 1926 Bodie, John Allen, 221 Columbus Ave.  
 1931 Bodie, William Joseph, 221 Columbus Ave.  
 1939 Boisvert, Paul Leo, 789 Howard Ave.  
 1919 Bretzfelder, Karl Benjamin, 315 Whitney Ave.  
 1935 Brody, Bernard Stephen, 303 Whitney Ave.  
 1945 Brody, John, 291 Whitney Ave.  
 1938 Bruckner, William J., 129 Whitney Ave.  
 1946 Bruno, Joseph Julius, 505 Whalley Ave.  
 1930 Bumstead, John Henry, 256 Bradley  
 1942 Bunting, Henry, 310 Cedar  
 1943 Calabresi, Massimo, 614 Orange  
 1934 Canfield, Norton, 789 Howard Ave.  
 1928 Capececiatro, Alfonso, 142 Columbus Ave.  
 1916 Carelli, Genesis Frank, 27 Elm  
 1943 Carlson, Robert Irving, 710 Woodward Ave.  
 1946 Castiglione, Frank Michael, 1305 State  
 1932 Celentano, Luca Eugene Humbert, 115 Howe  
 1943 Centrone, Patrick Anthony, 253 West Carlisle  
 1946 Cerrone, Luke John, 67 Chapel  
 1947 Cipriano, Anthony Pasquale, Grace Hospital  
 1946 Cheney, Charles Brooker, 789 Howard Ave.  
 1934 Claiborn, Louis Nixon, 303 Whitney Ave.  
 1937 Clark Mildred Helen, 244 Sherman Ave.  
 1938 Clarke, Clement Cobb, 60 Trumbull  
 1946 Clement, David Hale, 158 Whitney Ave.  
 1935 Climo, Samuel, 1172 Chapel  
 1923 Cobey, James Francis, 1210 Chapel  
 1922 Coffey, James Ryle, 216 Grand Ave.  
 1925 Cofrances, Louis William, 190 Winthrop Ave.  
 1904 Cohane, Timothy Francis, 400 Congress Ave.  
 1942 Cohen, Louis Harold, 315 Whitney Ave.  
 1924 Cohen, William, 1195 Chapel  
 1917 Collins, William Francis, 66 Trumbull  
 1921 Colwell, Howard Spencer, 129 Whitney Ave.  
 1914 Comfort, Charles Williams, Jr., 27 Elm  
 1931 Connolly, Arthur James, 59 Trumbull  
 1914 Conte, Harry Albert, 5 Elm  
 1939 Conte, Mario Gero, 175 Grand Ave.  
 1943 Conway, David Francis, Jr., 64 Trumbull  
 1921 Cook, Robert Jay, 85 Whitney Ave.  
 1931 Corradino, Charles Louis, 516 Howard Ave.  
 1944 Cramer, Sidney Leo, 789 Howard Ave.  
 1921 Creadick, Abraham Nowell, 79 Trumbull  
 1936 Culotta, Charles Salvatore, 291 Whitney Ave.  
 1946 Curnen, Edward Charles, Jr., 333 Cedar  
 1943 Curtis, William Boyd, 195 Church  
 1940 Cutler, Herman Shepard, 1308 Chapel  
 1924 Dallas, Marion, 248 Bradley  
 1943 D'Amico, Joseph, 197 James  
 1935 D'Amico, Michael, 291 Whitney Ave.  
 1946 Danowski, Thaddeus Stanley, 789 Howard Ave.  
 1934 Darrow, Daniel Cady, 789 Howard Ave.  
 1939 Davis, Jachin Boaz, 364 Oak  
 1946 Day, Harry Luther, 1076 Forest Rd.  
 1920 Dayton, Arthur Bliss, 129 Whitney Ave.  
 1942 de Forest, Gideon Knapp, 256 Bradley  
 1920 Deming, Charles Kenneth, 257 Church  
 1922 Deming, Clyde Leroy, 789 Howard Ave.  
 1925 Dennehy, William James, 158 Whitney Ave.  
 1935 D'Esopo, Joseph Nicholas, 33 Whitney Ave.  
 1943 de Suto-Nagy, Ilona Krasso, 158 Whitney Ave.  
 1940 DiStasio, Frank, 251 Edwards  
 1943 Doff, Simon David, 1142 Chapel  
 1922 Duffy, William Core, 608 Whitney Ave.  
 1943 Durlacher, Stanley Henry, 310 Cedar  
 1943 Epstein, Charles J., 265 Church  
 1923 Errico, Louis, 26 Elm  
 1946 Etkind, Meyer George, 1546 Chapel  
 1945 Evans, Joseph Harold, 1488 Chapel  
 1925 Evans, Theodore Schlosser, 59 Trumbull  
 1943 Eveleth, Malcolm Standish, 789 Howard Ave.  
 1935 Fenney, Philip William, 570 Elm St.  
 1942 Fiorito, Joseph Anthony, 255 Bradley  
 1929 Fiskio, Peter William, 215 Whitney Ave.  
 1945 FitzSimons, Edmund Francis, 19 Howe  
 1914 Flynn, Charles Thomas, 41 Trumbull  
 1929 Flynn, Harold Aloysius, 464 Dixwell Ave.  
 1946 Foord, Alan, 789 Howard Ave.  
 1888 Foote, Charles Jenkins, 230 Willow  
 1907 Ford, Alice Porter, 1400 Chapel  
 1929 Foster, Lewis Chandler, 256 Bradley  
 1924 Freedman, Barnett Philip, 322 George  
 1936 Freeman, David, 60 Trumbull  
 1940 Friedman, Irving, 121 Whitney Ave.  
 1937 Fry, Clements Collard, 109 College  
 1941 Fuldner, Russell Victor, 85 Trumbull  
 1940 Garofalo, Mario Louis, Hospital of St. Raphael  
 1938 Geiger, Arthur Joseph, 789 Howard Ave.  
 1945 Gencarelli, Alphonse Frank, 85 Trumbull  
 1937 Gentile, Angelo Louis, 601 Chapel  
 1920 Geraci, Lucian Arthur, 291 Whitney Ave.  
 1937 German, William John, 789 Howard Ave.  
 1941 Gerstl, Bruno, 524 George  
 1947 Gesell, Arnold, 14 Davenport Ave.  
 1923 Gettings, James Augustus, 209 Whalley Ave.  
 1924 Giamarino, Henry James, 291 Whitney Ave.  
 1943 Gillson, Reginald Eric, 255 Bradley  
 1946 Gilmer, Roy Jones, 259 Dixwell Ave.  
 1926 Glazer, Morris, 1204 Chapel  
 1946 Glorig, Aram, Jr., 789 Howard Ave.  
 1941 Godfried, Milton Simons, 85 Trumbull  
 1910 Goldberg, Samuel James, 43 Trumbull  
 1941 Goldberg, Samuel James, Jr., 43 Trumbull  
 1912 Goldman, George, 201 Park  
 1927 Goldstein, Morris, 451 George  
 1947 Gompertz, Michael Louis, 43 Trumbull  
 1941 Grady, Joseph Francis, 265 Church  
 1941 Granoff, Morris Aaron, 419 Whalley Ave.  
 1924 Greenhouse, Barnett, 107 Whitney Ave.  
 1927 Groark, Joseph Anthony, 145 Grand Ave.  
 1931 Grodin, Herman Wolmer, 840 Howard Ave.  
 1939 Guida, Francis Paul, 67 Trumbull  
 1936 Hankin, Morris Albert, 43 Trumbull  
 1930 Harris, Benedict Richard, 315 Whitney Ave.  
 1937 Harris, Jesse Samuel, 239 Bradley St.  
 1931 Harrison, Elizabeth Ross, 255 Bradley  
 1935 Hart, James Clement, 820 Elm  
 1920 Harvey, Samuel Clark, 789 Howard Ave.  
 1937 Hathaway, John Seabury, 109 College  
 1941 Heinemann, Martin, 107 Whitney Ave.  
 1916 Hendricks, Albert Ludwig, 26 Trumbull  
 1907 Henze, Carl William, 466 Orange  
 1943 Herrick, Francis Leach, Grace Hospital  
 1942 Hersey, Thomas Francis, 291 Whitney Ave.



- 1937 Hess, Orvan Walter, 79 Trumbull  
 1930 Higgins, Joseph John, 48 Dwight  
 1922 Hillman, Maurice Manuel, 31 Howe  
 1916 Hirata, Isao, 1455 Chapel  
 1943 Hitchins, Clayton Stanley, 59 Trumbull  
 1943 Hodgkins, Charles Henry, 59 College  
 1946 Hovenanian, Michael Simon, 789 Howard Ave.  
 1924 Howard, Albert Joseph, 432 Whalley Ave.  
 1935 Howard, Marion Edith, 789 Howard Ave.  
 1915 Hynes, Frederick Henry, 195 Church  
 1924 Jack, John Louis, 412 Orange  
 1936 Jackson, Edith Banfield, 333 Cedar  
 1943 Jaffe, Samuel A., 235 Bishop  
 1927 Jenkins, Ralph Hathaway, 789 Howard Ave.  
 1933 Johnson, Carl Edward, 364 Oak  
 1938 Jordan, Robert Hough, 64 Trumbull  
 1946 Josephs, William Walter, 1172 Chapel  
 1937 Kahn, Eugen, 35 Edgehill Rd.  
 1944 Kartin, Bernard Leon, 333 Cedar  
 1944 Katz, Harvey Warren, 291 Whitney Ave.  
 1946 Kertesz, Johann, 45 Trumbull  
 1942 Kirby, Sam Bartholomew, 461 Humphrey  
 1938 Klatskin, Gerald, 107 Whitney Ave.  
 1928 Klebanoff, Harry Erwin, 1497 Chapel  
 1917 Kleiner, Simon Bretzfelder, 315 Whitney Ave.  
 1940 Koufman, William Bernard, 121 Whitney Ave.  
 1935 Krosnick, Morris Yale, 257 Church  
 1937 Kushlan, Samuel Daniel, 303 Whitney Ave.  
 1940 Latimer, Marvin Luther, 129 Whitney Ave.  
 1942 Laube, Paul Julius, 789 Howard Ave.  
 1936 Laviates, Paul Harold, 340 Whitney Ave.  
 1915 Lear, Maxwell, 1172 Chapel  
 1944 Lennox, Margaret Agnes, 333 Cedar  
 1943 Leonard, Marion, 158 Whitney Ave.  
 1923 Levin, Hyman Alexander, 1142 Chapel  
 1920 Levy, Daniel Frederick, 1288 Chapel  
 1905 Lewis, Dwight Milton, 128 Crescent  
 1923 Lewis, Robert Morton, 52 Trumbull  
 1939 Liebow, Averill Abraham, 310 Cedar  
 1911 Linde, Joseph Irving, 161 Church  
 1943 Lindskog, Gustaf Elmer, 789 Howard Ave.  
 1919 Little, Herman Clark, 303 Whitney Ave.  
 1927 Logan, William Joseph, 412 Whalley Ave.  
 1944 Lolli, Giorgio, 4 Hillhouse Ave.  
 1942 Lowman, Robert Morris, 108 Livingston  
 1947 Lydon, Lawrence G. M., 45 Trumbull  
 1926 MacCready, Paul Beattie, 442 Temple  
 1946 Markoff, Abraham, 135 Whitney Ave.  
 1946 Marshak, Irving Jacob, 1142 Chapel  
 1927 Marshall, Carter Lee, 198 Dixwell Ave.  
 1928 Marvin, Harold Myers, 303 Whitney Ave.  
 1921 Massa, Anthony Francis, 24 Beers  
 1931 Mastroianni, Luigi, 248 Bradley  
 1938 Mathews, Frank Pelletreau, 109 College  
 1925 Maurer, Lloyd Leslie, 41 Trumbull  
 1920 Maynard, Harry Hilt, 882 Howard Ave.  
 1934 McAlenney, Paul Francis, Jr., 79 Trumbull  
 1922 McDonnell, Ralph Edward, 158 Whitney Ave.  
 1913 McGuire, William Charles, 104 Park  
 1940 Mendelsohn, William, 442 Temple  
 1916 Mendillo, Anthony Joseph, 45 Trumbull  
 1933 Mendillo, John Carleton Francis, 255 Bradley  
 1938 Mignone, Joseph, 291 Whitney Ave.  
 1947 Milici, John Joseph, 1342 Chapel  
 1942 Mogil, Marvin, 59 College  
 1930 Mongillo, Frank, 5 Elm  
 1946 Moore, Burness Evans, 333 Cedar  
 1942 Moore, Donald Bernard, 588 Howard Ave.  
 1945 Morgan, Kenneth Remsen, 168 Prospect  
 1946 Moss, Harry George, 646 Dixwell Ave.  
 1922 Musselman, Luther Kyner, 107 Whitney Ave.  
 1944 Mylon, Ernst, 358 Central Ave.  
 1921 Nahum, Louis Herman, 1142 Chapel  
 1940 Nesbit, Robert Raymond, 1442 Chapel  
 1946 Newman, Harry Rudolph, 1172 Chapel  
 1922 Newman, Joseph Thomas, 150 Shelton Ave.  
 1935 Newman, Richard, 235 Bishop  
 1914 Nichols, Ralph Wilbur, 57 Trumbull  
 1932 Nodelman, Jacob, 26 Elm  
 1947 O'Brasky, George Harry, 1172 Chapel  
 1933 O'Brasky, Louis, 1172 Chapel  
 1920 O'Brien, William Henry Joseph, 265 Church  
 1922 O'Connor, Denis Stanislaus, 158 Whitney Ave.  
 1931 Oughterson, Ashley Webster, 77 Howe  
 1936 Palmieri, Michael Walter, 551 Howard Ave.  
 1946 Pasternak, Maxwell, 235 Bishop  
 1929 Paul, John Rodman, 789 Howard Ave.  
 1943 Pelliccia, Orlando, Jr., 525 Whitney Ave.  
 1940 Perham, William Sidney, 129 Whitney  
 1922 Perrins, Harlan Bassett, 59 Trumbull  
 1925 Peters, John Punnett, 789 Howard Ave.  
 1927 Petrelli, Joseph, 455 Orange  
 1946 Petrillo, Charles, 67 Trumbull  
 1923 Philipson, Samuel, 100 Whitney Ave.  
 1909 Phillips, Frank Lyman, 303 Whitney Ave.  
 1935 Piazza, George Joseph, 78 Orchard  
 1942 Piccolo, Pasquale A., 41 Trumbull  
 1931 Pinn, Abraham Samuel, 75 Sherman Ave.  
 1942 Pitegoff, Charles Haskell, 1442 Chapel  
 1927 Poole, Allan King, 107 Whitney Ave.  
 1938 Poverman, David, 67 Trumbull  
 1927 Powell, Wilson, 1266 Forest Rd.  
 1925 Powers, Grover Francis, 789 Howard Ave.  
 1934 Rademacher, Everett Stanley, 442 Temple  
 1903 Rand, Richard Foster, 246 Church  
 1924 Raynolds, Randolph, 44 Trumbull  
 1943 Redlich, Frederick Carl, 333 Cedar  
 1941 Riccio, Joseph Salvatore, 1059 Dixwell Ave.  
 1924 Riccitelli, Mariano Louis, 476 Howard Ave.  
 1946 Richards, William Raymond, 364 Oak  
 1938 Rilance, Arnold Boon, 442 Temple  
 1929 Roberts, Frederick William, 158 Whitney Ave.  
 1920 Rogers, Orville Forrest, 109 College  
 1929 Rogowski, Bernhard Albert, 75 Whitney Ave.  
 1946 Rosenbaum, Jack Davidson, 789 Howard Ave.  
 1941 Roth, Oscar, 42 Trumbull  
 1932 Rothschild, Morris Loeb, 315 Whitney Ave.  
 1941 Rozen, Alan Abraham, 224 Norton  
 1937 Rubin, George Alan, 1150 Chapel  
 1914 Russell, Thomas Hubbard, 57 Trumbull  
 1922 Russell, Walter Irving, 317 Whalley Ave.  
 1920 Russo, Joseph Daniel, 255 Edwards  
 1921 Ryder, William Harold, 195 Church  
 1945 Sachs, Kurt, 1442 Chapel  
 1933 Salinger, Robert, 256 Bradley  
 1944 Salter, William Thomas, 333 Cedar  
 1911 Scarbrough, Marvin McRae, 47 Trumbull  
 1931 Scholl, Robert Frederick, 215 Whitney Ave.  
 1924 Scott, Clifton Russell, 215 Whitney Ave.  
 1920 Seabury, Robert Brewster, 315 Whitney Ave.  
 1916 Segnalla, Ernest, 613 Chapel  
 1923 Serafin, Peter James, 809 State  
 1946 Shaffer, Irvin George, 291 Whitney Ave.  
 1928 Shay, Francis Leo, 354 Alden Ave.  
 1923 Shea, Michael Stephen, 500 Howard Ave.  
 1915 Sheahan, William Lawrence, 59 College

- 1946 Shumacker, Harris B., Jr., 789 Howard Ave.  
 1929 Shure, Abraham Lewis, 1184 Chapel  
 1947 Sigal, Harry, 85 Trumbull  
 1923 Silverberg, Samuel Joshua, 315 Whitney Ave.  
 1913 Skiff, Stuart Ernest, 1194 Chapel  
 1944 Smirnow, Max Ruskin, 1142 Chapel  
 1923 Smith, Charles Seaver, 59 College  
 1942 Smith, Frederick Francis, 84 Dixwell Ave.  
 1914 Smith, Marvin, 356 Humphrey  
 1940 Smith, Norman Nathaniel, 291 Whitney Ave.  
 1946 Snoke, Albert Waldo, 789 Howard Ave.  
 1927 Snurkowski, Charles Vincent, 487 Orange  
 1927 Sperandeo, Anthony, 441 Orange  
 1896 Sperry, Frederick Noyes, 107 Whitney Ave.  
 1942 Spiegel, Charles Markle, 59 College  
 1939 Spinner, Samuel, 85 Trumbull  
 1907 Standish, Frank Billings, 193 York  
 1916 Stewart, Harry Eaton, 262 Bradley  
 1946 Stilson, Carter, 158 Whitney Ave.  
 1925 Stone, Emerson Law, 129 Whitney Ave.  
 1920 Strauss, Maurice Jacob, 41 Trumbull  
 1897 Sullivan, John Francis, 1346 Chapel  
 1923 Sullivan, Thomas Joseph, 495 Orange  
 1946 Swift, William Everett, Jr., 789 Howard Ave.  
 1946 Swirsky, Morgan Yale, 1204 Chapel  
 1946 Taffel, Max, 789 Howard Ave.  
 1946 Tager, Morris, 333 Cedar  
 1947 Thompson, Walter Andrew Lewis, 158 Whitney Ave.  
 1915 Thoms, Herbert, 789 Howard Ave.  
 1940 Thorne, Lewis, 109 College  
 1911 Tileston, Wilder, 442 Temple  
 1947 Tortora, Frank, 386 Ferry  
 1923 Tyler, Margaret, 158 Whitney Ave.  
 1942 Vegliante, Michael E., 174 Bradley  
 1896 Verdi, William Francis, 27 Elm  
 1943 Verstandig, Charles Coleman, 129 Whitney Ave.  
 1924 Vestal, Paul William, 79 Trumbull  
 1941 Vollero, Andrew, 469 Howard Ave.  
 1926 Wakeman, Edward Taylor, 129 Whitney Ave.  
 1945 Waldemar-Kertész, Johanna, 201 Park  
 1919 Weil, Arthur, 291 Whitney Ave.  
 1942 Weir, Margaret Lathrop Bronson, 200 Edgehill Rd.  
 1902 Welch, Harry Little, Hotel Taft  
 1907 Wheatley, Louis Frederick, 61 Trumbull  
 1916 Whiting, Leonard Clark, 121 Whitney Ave.  
 1936 Wies, Frederick Albert, 255 Bradley  
 1941 Wilkinson, Arthur Gilbert, 59 Trumbull  
 1947 Willard, William Robert, 310 Cedar  
 1931 Willner, Otto, 61 Trumbull  
 1947 Wilson, Charles Christopher, 310 Cedar  
 1935 Wilson, Hugh Monroe, 789 Howard Ave.  
 1931 Wilson, William Rives, 255 Bradley  
 1947 Winer, Paul, 204 Park  
 1899 Winne, William Nelson, 1020 Whalley Ave.  
 1921 Winternitz, Milton Charles, 310 Cedar  
 1922 Winters, Sidney, 1175 Chapel  
 1895 Wurtenberg, William Charles, 445 St. Ronan  
 1924 Yavis, John Constantine, 115 Dwight  
 1920 Yudkin, Arthur Meyer, 257 Church  
 1942 Zaff, Fred, 135 Whitney Ave.

## NORTH HAVEN

- 1941 Cashman, Justin Laurence, Broadway  
 1943 Gillis, Grace Elaine, St. John  
 1913 Lang, William Peter, The Cedars  
 1940 Parrella, Louis Arnold, Broadway  
 1923 Taylor, Sterling Price, Broadway and Post Rd.

## SEYMOUR

- 1938 Chobian, Joseph Aloysius, 195 Main  
 1941 Harvey, Edward Regis, 119 Main  
 1946 Harvey, Edward Regis, Jr., 119 Main  
 1934 Rogol, Oscar, 135 Main

## SOUTHBURY

- 1942 Deutsch, Joyce Victoria, Southbury Training School  
 1935 Yannet, Herman, Southbury Training School

## WALLINGFORD

- 1943 Boyarsky, Harry Morton, 450 Center  
 1932 Breck, Charles Arthur, 176 North Main  
 1929 Campbell, Sherburne, 270 Center  
 1930 Carrozella, John Christy, 50 South Main  
 1941 Dayton, Theodore Read, Gaylord Farm  
 1942 Ferguson, James Fulton, Jr., 176 North Main  
 1942 Gushee, Edward Stockbridge, 187 North Main  
 1946 Konopka, Frank Joseph, 1 William  
 1905 Lyman, David Russell, Gaylord Farm  
 1911 McGaughey, James David, 261 Center  
 1947 McGaughey, James David, III, 424 North Main  
 1916 Morris, William Haviland, Gaylord Farm  
 1942 Murphy, Thomas Basil, 324 North Elm  
 1940 Pelz, Kurt, 26 South Main  
 1919 Sheehan, Mark Thomas, 245 Center  
 1931 Spignesi, John Theodore, 37 North Main

## WATERBURY

- 1924 Allen, Harry Everett, 30 Prospect  
 1929 Atkins, Samuel Maurice, 63 Central Ave.  
 1923 Audet, Charles Henry, 42 Church  
 1942 Backhus, Louis Charles, 79 Greenleaf Ave.  
 1910 Barber, Walter Lewis, Jr., 87 North Main  
 1937 Berman, Bernard Alfred, 147 Columbia Blvd.  
 1908 Bevans, Theodore Frank, 111 West Main  
 1931 Bizzozero, Orpheus Joseph, 20 Grove  
 1942 Blau, Rudolf, 47 Cooke  
 1946 Bloomberg, Maxwell H., 53 Cooke  
 1939 Bonner, Robert Alexander, 51 West Main  
 1943 Bonner, Robert Alexander, Jr., 103 North Main  
 1943 Bowen, Joseph John, Jr., 81 Alma  
 1910 Brennan, Patrick Joseph, 135 West Main  
 1928 Brown, Abe Solomon, 58 Central Ave.  
 1940 Burke, Joseph Francis, 39 Central Ave.  
 1945 Carpentieri, Anthony Louis, 18 Aetna  
 1941 Cole, Clarence Hummer, 111 West Main  
 1935 Collins, Joseph Osborn, 64 Robbins  
 1942 Coppeto, Carmine James, 220 East Main  
 1932 Corbett, Herbert John, 14 Central Ave.  
 1942 Coshak, Morris, 58 Holmes Ave.  
 1928 Cottiero, Thomas, 21 Cooke  
 1947 Cox, Marcus Edward, St. Mary's Hospital  
 1928 Curran, Harold Joseph, 111 West Main  
 1940 Damiani, Rudolph Andrea, 5 Cooke  
 1942 DeCristoforo, Ralph, 291 North Main  
 1912 Dillon, John Henry, 325 East Main  
 1941 Dionne, Ulric Albany, 64 Holmes Ave.  
 1927 Dreher, Alfred Charles, 171 North Main  
 1941 DuBois, Robert Lionel, 29 Central Ave.  
 1947 Dwyer, Christopher Edward, 18 Pine  
 1902 Dwyer, Patrick James, 95 North Main  
 1927 Edlin, Charles, 24 Central Ave.  
 1922 Fabricant, Samuel Elmer, 9 Cooke  
 1937 Finkelstein, William, 103 North Main



1926 Finn, Alfred Joseph, 164 West Main  
 1926 Fitzpatrick, Edward Earl, 111 West Main  
 1927 Foster, John Hess, 77 North Main  
 1928 Freiheit, John Martin, 85 Grove  
 1909 Gancher, Jacob, 275 North Main  
 1923 Godfrey, Edward John, 235 Grand  
 1914 Good, William Murray, 63 Center  
 1915 Green, Jacques Henry, 171 North Main  
 1947 Grillo, William, 56 Franklin  
 1947 Hanson, Millard Charles, 95 North Main  
 1942 Harty, John E., 101 North Main  
 1933 Harvey, Joseph LeRoy, 222 Ledgeside Ave.  
 1930 Herrmann, Albert Edward, 111 West Main  
 1931 Hetzel, Joseph Linn, 51 Central Ave.  
 1939 Hinchey, Richard James, 43 Central Ave.  
 1919 Jackson, Andrew Joseph, 111 West Main  
 1947 James, Mary Latimer, 7 First Ave.  
 1942 Jennes, Milton Leo, 76 Center  
 1939 Jennes, Sidney Weinberg, 135 West Main  
 1922 Johnson, Arthur August, 59 Central Ave.  
 1915 Johnston, Ernest Hillock, 18 Saving  
 1944 Karlin, Frank Lewis, 95 North Main  
 1946 Kelly, LeMoyne Copeland, 95 North Main  
 1914 Kirschbaum, Edward Harry, 20 Grove  
 1944 Koleshko, Lawrence Jacob, 24 Central Ave.  
 1940 LaBrecque, Frederick Charles, 77 Central Ave.  
 1922 Larkin, Charles Lewis, 101 North Main  
 1945 Lenkowski, William John, 207 South Elm  
 1907 Leonard, George Arthur, 79 North Main  
 1941 Lewicki, Edward Stanley, 36 North Main  
 1924 Lombardi, Pasquale Frederick, 46 Prospect  
 1946 Mangeniello, Louis Ottone Joseph, 29 Lexington Ave.  
 1939 Margolius, Norman Calvin, 50 Holmes Ave.  
 1941 Mayo, Elliott Russell, 129 Prospect  
 1916 McGrath, John Henry, 309 East Main  
 1943 Meo, Richard Carl, 80 Central Ave.  
 1941 Merriman, Henry, 115 Prospect  
 1925 Merriman, Merritt Heminway, 115 Prospect  
 1928 Morrill, Harold Frost, 300 West Main  
 1932 Mullen, John Joseph, 135 West Main  
 1947 Mulligan, Thomas Michael, 19 Holmes Ave.  
 1929 Neuswanger, Chris Harold, 89 North Main  
 1942 Pasetto, Edo, 63 Central Ave.  
 1923 Platt, Irving Smith, 30 Prospect  
 1943 Pollard, Robert Lonsdale, 24 Central Ave.  
 1901 Pomeroy, Nelson Asa, 96 Hillside Ave.  
 1940 Post, Edward Andrew, 111 West Main  
 1943 Prior, John D., 64 Robbins  
 1931 Pyle, Edwin, 95 North Main  
 1916 Quinn, Raymond James, 730 Baldwin  
 1941 Reichenbach, Alfred Edelbert, 171 North Main  
 1939 Reynolds, Joseph Alban, 135 West Main  
 1920 Root, James Harold, 103 North Main  
 1947 Root, James Harold, Jr., 103 North Main  
 1946 Rosenberg, Harold Arthur, 29 Central Ave.  
 1925 Ruby, Max Harold, 47 Prospect  
 1939 Ruby, Robert James, 47 Prospect  
 1914 Ryder, Raymond Harrison, 52 Central Ave.  
 1941 Saltzman, Jacob A., 135 West Main  
 1931 Sandulli, Gaetano Renato, 64 Cooke  
 1928 Santoro, Grace Marie, 95 North Main  
 1933 Shea, Vincent Timothy, 20 East Main  
 1941 Sklaver, Joseph, 95 North Main  
 1935 Slavin, Joseph E., 79 North Main  
 1906 Smith, Egbert Livingston, 292 West Main  
 1946 Smith, Jasper Archer, 77 Central Ave.  
 1915 Spicer, Edmund, 292 West Main  
 1931 Staneslow, John Stanislovaitis, 21 Holmes Ave.  
 1924 Stettbacher, Henry John, 28 Prospect

1946 Sullivan, Arthur Francis, 111 West Main  
 1906 Swenson, Andrew Clay, 43 Central Ave.  
 1947 Teiger, Paul, 58 Holmes Ave.  
 1947 Tynan, James G., 101 Fuller  
 1916 Vastola, Anthony Patrick, 103 North Main  
 1920 Webber, Edwin Russell, 95 North Main  
 1944 Wertheimer, John, 195 North Main  
 1946 Whalley, Evan Joseph, 720 Baldwin  
 1942 Wilcox, Frederick C., Jr., 64 Robbins  
 1943 Zerkowitz, Frederick, 79 North Main  
 1942 Zonn, Seymour Israel, 34 Holmes Ave.

## WEST HAVEN

1945 Albom, Jack Jonathan, 336 Main  
 1929 Appell, Harold Seymour, 354 Campbell Ave.  
 1938 Chasnoff, John Arthur, 328 Main  
 1943 Cozzolino, Eugene Norris, 640 Savin Ave.  
 1923 Giannotti, Carl Charles, 399 Savin Ave.  
 1909 Gilmore, Joseph Leo, 191 Center  
 1943 Kessler, Frederick, 233 Elm  
 1940 Koster, Leo William, 381 Main  
 1904 Kowalewski, Victor Alexander, 597 Campbell Ave.  
 1930 Milano, Nicolas Antonio, 271 Elm  
 1923 O'Connell, William Michael, 295 Main  
 1915 Rogers, Platt Harrison, 228 Elm  
 1945 Saposnik, Jacob Jay, 610 Campbell Ave.  
 1933 Snavely, Marion Elizabeth, 546 Washington Ave.

## OUT OF COUNTY

1935 Abbey, Edward Augustin, 370 South East Second, Ft. Lauderdale, Florida  
 1937 Abrashkin, Mortimer Dick, 393 West End Ave., New York City  
 1908 Arnold, Harold Sears, Woodbridge  
 1946 Banay, Ralph Steven, 709 Park Ave., New York City  
 1946 Barald, Fred Charles, Veterans Hospital, Jefferson Barracks, Mo.  
 1934 Bayne-Jones, Stanhope, 525 East 68th, New York City  
 1907 Blumer, George, 65 North Madison Ave., Pasadena, California  
 1940 Brown, Warren Thompson, Baylor University, College of Medicine, Houston, Texas  
 1932 Budau, John Harry Diederichs, P. O. Box 148, Rockledge, Florida  
 1924 Carroll, William Edward, 184 North Walnut, East Orange, N. J.  
 1946 Cressy, Norman Leo, Veterans Hospital, Newington  
 1947 Crispell, Lawrence Stearns, 840 Clinton Ave., Bridgeport  
 1921 Dunham, Ethel Collins, 1815 45th, N. W., Washington, D. C.  
 1916 Egan, John Joseph, U. S. Vets. Admin., Newington  
 1937 Eliot, Martha May, 1815 45th, N.W., Washington, D.C.  
 1925 Fox, James Charles, Jr., 20 South Hudson, Hartford  
 1946 Gardner, Horace Tillman, Cornell Medical College, 1300 York Ave., New York 21, N. Y.  
 1939 Gendel, Benjamin Robert, Kennedy Veterans Hospital, Memphis, Tenn.  
 1940 Goodrich, William Albert, 179 Allyn St., Hartford  
 1941 Grillo, Vincent James, N. Y. Orthopedic Hospital, New York City  
 1943 Harvey, Thomas Stoltz, Philadelphia General Hospital, Philadelphia, Penn.  
 1942 Havill, Rupert A., Auburn City Hospital, Auburn, N.Y.  
 1943 Hieronymus, Ethel Emelia, 1304 Everett Ave., Louisville, Ky.  
 1943 Hoff, Ebbe Curtis, Medical College of Virginia, Richmond, Va.

- 1946 Howard, Weaver Oscar, Veterans Hospital, Tuskegee, Alabama
- 1929 Hughson, Donald Thomas, Bellevue Hospital, New York City
- 1927 Johnson, Harold Albert, R. F. D. #2, Watertown
- 1936 Klumpp, Theodore George, 170 Varick St., New York City
- 1942 Krosnick, Gerald, 818 Harrison Ave., Boston, Mass.
- 1935 Leddy, Percy Allen, 15 Mitchell, South Portland, Me.
- 1945 Lepreau, Frank James, Jr., 94 Hawthorne, New Bedford, Mass.
- 1927 Lindsay, Merrill Kirk, 2650 Wisconsin Ave., Washington, D. C.
- 1944 Lockwood, John Salem, 630 West 168th, New York, N. Y.
- 1943 Lutz, Walter G., Yale Club, New York City
- 1944 McCabe, Edward James, 2 East 55th, New York City
- 1906 McLarney, Thomas Joseph, 67 Catherine St., Hartford
- 1917 Merrill, William Truman, 67 Fullers Lane, Milton, Mass.
- 1942 Millen, Samuel R., Veterans Home, Rocky Hill
- 1943 Mott, Frederick Edward, 29 Green Ave., Brooklyn, N. Y.
- 1940 Nelson, Roger Burdette, 114 West Buffalo, Ithaca, N.Y.
- 1946 Parrella, Gioachino Sisto, Veterans Administration, Newington
- 1894 Peck, Robert Ellsworth, R. F. D. No. 2, Concord, New Hampshire
- 1947 Rogawski, Alexander Simon, Beverly Hills, California
- 1936 Stevens, Marvin Allen, 71 Park Ave., New York City
- 1940 Sadusk, Joseph Francis, Jr., 402 Tremont Pl., Orange, N. J.
- 1910 Sanford, Charles Edwin, 1410C. 125th, Seattle, Wash.
- 1946 Saunders, Allen Irving, 54 Elm Hill Ave., Roxbury, Mass.
- 1939 Sayers, Daniel O'Connell, Winter General Hospital, Topeka, Kansas
- 1941 Sword, Brian Collins, 630 North Broadway, Yonkers, N. Y.
- 1942 Tarbell, Luther Allen, Veterans Administration, Batavia, N. Y.
- 1936 Van Antwerp, Lee Douglas, Box 5110, Chicago, Ill.
- 1945 Wagner, Herbert Theodore, Jr., 5235 Graceland Ave., Indianapolis, Indiana
- 1946 Weed, Chester Albert, Manhattan Eye, Ear, Nose and Throat Hospital, 210 East 64th, New York City
- 1942 Wentworth, John Hall, 50 Frost, Cambridge, Mass.
- 1933 Wilson, George Campbell, 92 Varick Rd., Waban, Mass.
- 1942 Woodruff, Lorande Mitchell, 721 Huntington Ave., Boston, Mass.
- 1933 Zimmerman, Harry Martin, Montefiore Hospital, New York City

## New London County Association

*President:* ALFRED LABENSKY, 85 Federal St., New London

*Vice-President:* HENRY A. ARCHAMBAULT, 2 North Second Ave., Taftville

*Secretary-Treasurer:* THOMAS SOLTZ, 52 Huntington St., New London

*Councilor:* GEORGE H. GILDERSLEEVE, 310 Main St., Norwich

Annual Meeting, First Thursday in April

Semi-Annual Meeting, First Thursday in October

## COLCHESTER

- 1935 Friedman, Irving, 16 Norwich Ave.
- 1921 Pendleton, Cyrus Edmund, 13 Main
- 1942 Schwarz, Hans Peter, 11 Main

## EAST LYME

### NIANTIC

- 1941 Dart, Frederick Bond, 61 Main
- 1934 MacLeod, Edith Alice, State Farm for Women

## GRISWOLD

### JEWETT CITY

- 1916 McLaughlin, John Henry, 37 Main
- 1934 O'Neil, Martin Leo, 8 Park Sq.

## GROTON

- 1916 Barnum, Charles Gardner, 230 Thames
- 1918 Douglass, Edmund Latham, 188 Thames
- 1943 Goldmeier, Erich, 274 Thames
- 1934 Hewes, Carlisle Tyson, 242 Thames
- 1941 Kaschub, Robert W., Electric Boat Co.
- 1944 Sutton, Paul, 280 Mitchell
- 1942 Szlemko, Emil Alex, 27 Poquonnock Rd.

## LYME

- 1927 Ely, Julian Griffin, R. F. D. No. 2

## MONTVILLE

### UNCASVILLE

- 1944 Donohue, John Daniel
- 1936 Lubchansky, Jacob Harris
- 1929 Rasmussen, Hans Norman

## NEW LONDON

- 1933 Becker, Joseph, 56 State
- 1928 Blank, Eric Henry, 240 Williams
- 1933 Brosnan, John Francis, 302 State
- 1916 Cheney, George Philip, 179 Montauk Ave.
- 1936 Comstock, Edward Richard, 108 State
- 1938 DeAngelis, Louis, 260 Broad
- 1909 Dunn, Frank Martin, 26 Broad
- 1931 Dyer, Charles Edward, 102 Montauk Ave.
- 1936 Ferguson, Helen Knox, 508 Montauk Ave.
- 1906 Ganey, Joseph Matthew, 205 Williams
- 1934 Gipstein, Edward, 181 Broad
- 1947 Grayson, Merrill, 183 Williams
- 1947 Haines, Henry Lippincott, 309 State
- 1939 Hartman, Frederick Bittinger, 58 Huntington
- 1922 Hendel, Isidor, 50 State
- 1902 Henkle, Emanuel Alex, 51 Federal
- 1934 Henkle, Robert Theodore, 51 Federal
- 1895 Heyer, Harold Hankinson, 70 Coit
- 1936 Irwin, Harold Hyman, 158 Williams
- 1921 Kaufman, Charles, 308 State
- 1940 Krinsky, Charles Morris, 302 State
- 1924 Labensky, Alfred, 85 Federal
- 1921 Lena, Hugh Francis, 154 Broad
- 1931 Loiacono, Anthony Joseph, 325 State
- 1946 MacDougall, Archibald Duncan, Lawrence and Memorial Hospital
- 1934 Morse, Willard Jackson, 32 Channing
- 1921 Murray, Thomas J., 34 Huntington
- 1946 Nielsen, Tage M., 195 Williams
- 1936 Rapp, Albert Grant, 325 State
- 1929 Satti, Charles John, 131 Montauk Ave.



1933 Scoville, Dorothea Haven, 40 Channing  
1938 Smilgin, Victor Edward, 265 Williams  
1921 Soltz, Thomas, 52 Huntington  
1929 Starr, Richard Mallory, 45 Huntington  
1942 Sturtevant, James Melvin, 58 Huntington  
1904 Sullivan, Daniel, 833 Ocean Ave.  
1940 Sulman, Morris, 203 Montauk Ave.  
1899 Taylor, John Clifton, 159 State  
1933 Taylor, Robert Nelson, 159 State  
1936 Ward, Lawrence Shapiro, 325 State  
1925 Warren, Hill Freeman, 100 State  
1922 Wellington, Harold Wentworth, 309 State  
1935 Wies, Carl Hendricks, 58 Huntington  
1913 Wilson, Frank Emery, 302 State  
1938 Woodward, Joseph Cutler, 116 Federal St.

NORWICH

1910 Agnew, Robert Robertson, 257 Main  
1946 Albamonti, Mario John, 257 Main  
1935 Bergendahl, Harold Andrew, 63 Broadway  
1942 Bielecki, Casimer Eugene, 35 Main  
1908 Brophy, Edward Joseph, 242 Washington  
1945 Bryan, Kathryn May, 2 Franklin  
1916 Callahan, John William, 308 Main  
1915 Campbell, Hugh Baird, 275 Broadway  
1947 Colett, Ilse Vivien, Norwich State Hospital  
1943 Daly, Joseph Lawrence, Jr., Norwich State Hospital  
1946 Danburg, Dwight Sterling, Uncas-on-Thames  
1925 Dixon, Henry Campbell, 16 Franklin  
1897 Donohue, James Joseph, 43 Broadway  
1916 Driscoll, William Thomas, 257 Main  
1942 Drobnos, Sidney, 71 Main  
1942 Ferrara, Michael, Uncas-on-Thames  
1916 Freeman, Albert Clark, 54 Broadway  
1942 Friedman, Emerick, Box 508  
1898 Gildersleeve, Charles Child, 29 Lincoln Ave.  
1927 Gildersleeve, George Harold, 310 Main  
1946 Gould, Louis N., Norwich State Hospital  
1945 Guthrie, Riley Henry, Norwich State Hospital  
1935 Hale, Virginia Anne, Norwich State Hospital  
1935 Higgins, Harold William, 40 Shetucket  
1898 Higgins, Harry Eugene, 40 Shetucket  
1946 Kelley, Winfield Orthello, Uncas-on-Thames  
1938 Kettle, Ronald Harry, Norwich State Hospital  
1936 Mahoney, Joseph John, 99 Main  
1922 Manwaring, Ier Jay, East Great Plains  
1922 Markoff, Kopland Karl, 16 Franklin  
1937 Moore, Maurice R., 88 Central Ave.  
1935 Neumann, Virgil Frank, Uncas-on-Thames  
1935 O'Connell, Patrick Henry, 10 Shetucket  
1942 Oppenheimer, Kurt, 257 Main  
1936 Osgood, Charles, 257 Main  
1942 Pepe, Anthony James, Norwich State Hospital  
1934 Quintiliani, Albert, 43 Broadway  
1932 Rabinovitch, Alec, 96 McKinley Ave.  
1935 Sears, Lewis, 257 Main  
1938 Segel, Solam, 257 Main  
1944 Smith, Bryce A., Uncas-on-Thames  
1929 Suplicki, John William, 257 Main  
1921 Sussler, David, 65 Main  
1925 Thompson, Clarence George, 257 Main  
1931 Urquhart, Robert Glen, 91 Main  
1935 Weidman, William Harold, Uncas-on-Thames  
1932 Wener, William Victor, 241 Main

TAFTVILLE

1933 Archambault, Henry Allard, 2 North Second Ave.

OLD LYME

1909 Devitt, Ellis King  
1947 Von Glahn, Harold Diedrich, Ferry Rd.

STONINGTON

1934 Haliday, Earle George, 168 Water  
1934 Veal, William Thomas, 99 Water

MYSTIC

1947 Crandall, Bradford Blanchard, 31 Gravel  
1941 Fowler, Roger Nathaniel, 5 Library  
1928 Hill, Edward Roland, 43 East Main  
1947 Platt, John Wadsworth, 8 Elm  
1941 Ryley, Roger Noyes, 35 Willow

WATERFORD

1946 Coppola, Edward Attilio, 2 Highland Dr.  
1935 Lukoski, Walter Anthony Francis, The Seaside  
1913 O'Brien, John Francis, The Seaside  
1942 Tombari, Seraphino Paul, The Seaside

OUT OF COUNTY

1932 Griswold, Matthew, 154 Armory, New Haven  
1946 Mezey, Cornelius M., Columbus Hospital, Great Falls, Montana  
1941 Morris, Joyce Stringer, Greenwich Hospital, Greenwich  
1942 Oppen, Lincoln, Charlotte Hungerford Hospital, Torrington  
1940 Sabloff, Jack, 165 Capitol Ave., Hartford  
1943 Tissenbaum, Morris Joseph, 6 West 87th, New York City  
1912 Williams, Charles Mallory, 38 West, Nassau, B. W. I.

Tolland County Association

*President:* JOHN E. FLAHERTY, 42 Elm St., Rockville  
*Vice-President:* JOHN P. HANLEY, 15 Church, Stafford Springs  
*Secretary:* FRANCIS H. BURKE, 45 Park St., Rockville  
*Councilor:* CHARLES T. LAMOURE, Windham Center

Annual Meeting, Third Tuesday in April  
Semi-Annual Meeting, Third Tuesday in October

COVENTRY

SOUTH COVENTRY

1891 Higgins, William Lincoln

ELLINGTON

1940 Levine, Leonard Warren

SOMERS

1946 Schillander, Carl Axel, Box 100  
1921 Thayer, Ralph Bruce, Main

STAFFORD

STAFFORD SPRINGS

1908 Hanley, John Patrick, 15 Church  
1941 Luckner, Wendelin George  
1935 Schiavetti, Alfred, 11 Church

VERNON

ROCKVILLE

1933 Burke, Francis Henry, 45 Park  
1908 Dickinson, Francis McLean, 38 Elm

- 1923 Ferguson, Roy Cameron, 57 Union  
 1947 Firestone, Siegfried David, 56 Park  
 1918 Flaherty, John Edward, 42 Elm  
 1921 Metcalf, Elliott Harrison, 50 Elm  
 1897 O'Loughlin, Thomas Francis, 26 North Park  
 1931 Schneider, William, 34 Union  
 1946 Squillante, Orlando John, 28 Elm

## WILLINGTON

## WEST WILLINGTON

- 1928 Converse, Frank Benjamin

## OUT OF COUNTY

- 1918 LaMoure, Charles TenEyck, Windham Center  
 1940 Leonard, Robert John, Hospital of St. Raphael, New Haven

## Windham County Association

*President:* MOSES MARGOLICK, 80 Main St., Putnam  
*Vice-President:* REUBEN ROTHBLATT, 672 Main St., Willimantic  
*Secretary:* BRAE RAFFERTY, 807 Main St., Willimantic  
*Councilor:* KARL T. PHILLIPS, 66 Main St., Putnam

Annual Meeting, Third Thursday in April  
 Semi-Annual Meeting, Third Thursday in October

## HAMPTON

- 1914 Marsh, Arthur Drought

## KILLINGLY

## DANIELSON

- 1935 Chartier, Gerard Marcel, 148½ Main  
 1928 Garcin, Cecil Redvers, 7 Broad  
 1940 Laakso, Andrew Olavi, 39 Broad  
 1909 Perreault, Joseph Napoleon, 43 Main  
 1919 Tanner, Warren Avery, 36 Academy  
 1920 Todd, Frank Paige, 178 Main

## MOOSUP

- 1940 Couture, Arthur Joseph, 19 South Main  
 1946 Woodworth, John Albert, 1 Main

## PLAINFIELD

- 1903 Chase, Arthur Alverdo, Railroad Ave.  
 1933 Gulino, Angelo James

## PUTNAM

- 1942 Bates, David Hinrichs, 28 Front  
 1934 Chapnick, Morton Herman, 168 Main  
 1947 Dinolt, Robert, Bradley Theater Building  
 1941 Margolick, Moses, 80 Main  
 1921 Phillips, Karl Tristram, 66 Main  
 1930 Prosser, Florence Dean, 158 Main  
 1922 Russell, John Jarvis, Bridge and Main  
 1934 Shepard, William Mac, 66 Main

## WINDHAM

## WILLIMANTIC

- 1935 Arnold, Morton, 781 Main  
 1947 Baker, Conrad Stolzenbach, Windham Community Memorial Hospital  
 1939 Basden, Edward Herbert, 199 Church  
 1939 Carter, George Howard, 29 North  
 1901 Girouard, Joseph Arthur, 19 Union  
 1928 Kinney, Kenneth Kyle, 29 North  
 1940 Little, Mervyn Henry, 715 Main  
 1940 Little, Olga A. G., 715 Main  
 1947 Maurer, William Spooner, 670 Main  
 1925 Ottenheimer, Edward Joseph, Windham Community Hospital  
 1932 Rafferty, Brae, 807 Main  
 1930 Raymer, John George, Windham Community Hospital  
 1916 Riordan, Michael Davitt, 59 Church  
 1936 Roch, George Emile, 283 Prospect  
 1937 Rothblatt, Reuben, 672 Main  
 1914 Smith, Fred Morse, 736 Main  
 1929 Spector, Nathan, 59 Church  
 1935 Vernon, Sidney, 8 Willard

## WOODSTOCK

## EAST WOODSTOCK

- 1913 Pike, Ernest Reginald

## OUT OF COUNTY

- 1944 Curtis, Alton Kallock, 36 Porter, East Hartford  
 1946 Dayton, Neil Avon, State Training School, Mansfield Depot  
 1932 Gilman, Ralph Lawrence, Storrs  
 1896 Hills, Laura Heath, Winter Haven, Florida  
 1942 Leary, Deborah Cushing, Washington, D. C.  
 1946 Moxon, Gail Fitch, State Training School, Mansfield Depot  
 1936 Roy, Joseph Lambert, 222½ Arkona Court, West Palm Beach, Florida  
 1946 Flynn, Herbert Lawrence, Mansfield State Training School, Mansfield Depot  
 1944 Welt, Louis Gordon, Division of Research and Education, Veterans Administration, Washington, D. C.  
 1947 Whalin, Marion Louise, Storrs

## ASSOCIATE MEMBERS

- 1941 Burr, Harold Saxon, 333 Cedar, New Haven  
 1947 Darling, George Bapst, Woodbridge Hall, Yale University, New Haven  
 1941 Fulton, John Farquhar, 333 Cedar, New Haven  
 1941 Haggard, Howard W., 4 Hillhouse Ave., New Haven  
 1942 Hamilton, James A., University of Minnesota, Minneapolis, Minn.  
 1941 Hiscock, Ira Vaughn, 215 Highland, New Haven  
 1941 Long, Cyril N. Hugh, 333 Cedar, New Haven  
 1941 Mickle, Friend Lee, P. O. Box 1139, Hartford  
 1943 Schneider, Edward Christian, Wesleyan University, Middletown



## ALPHABETICAL ROLL OF MEMBERS

## With date and place of graduation

- Aaronson, M. S., Univ. & Bellevue '13, Ansonia  
 Abbey, E. A., Georgetown '30, Ft. Lauderdale, Fla. (New Haven County)  
 Abrahams, M., Tufts '31, New Canaan  
 Abrahamson, R. H., McGill '30, Stamford  
 Abrashkin, M. D., Maryland '32, New York City (New Haven County)  
 Adams, F. S., Yale '25, Canaan  
 Adams, A. J., Indiana '38, Torrington  
 Adams, M., Johns Hopkins '29, Greenwich  
 Adzima, J. M., Maryland '27, Bridgeport  
 Affinito, T., McGill '31, Meriden  
 Agnew, R. R., Yale '08, Norwich  
 Aiello, L. J., Boston '35, New Haven  
 Akerson, I. B., Iowa '25, Bridgeport  
 Albamonti, M. J., Tufts '38, Norwich  
 Albom, J. J., Columbia '39, West Haven  
 Alderman, I. S., Columbia '19, New Haven  
 Aldwin, F. J., Yale '32, Stamford  
 Alexander, S. J., Univ. & Bellevue '32, Middletown  
 Allen, E. P., Yale '24, New Haven  
 Allen, G. F., McGill '37, Hartford  
 Allen H. E., Bowdoin '19, Waterbury  
 Allen, J. C., Hahnemann '39, New Haven  
 Allen, M. F., Med. Chi., Phila. '95, New Haven  
 Allen, M. M., Woman's Medical '35, Hartford  
 Allen, W. M., Johns Hopkins '20, Hartford  
 Alley, R. D., Yale '43, New Haven  
 Alling, A. N., Columbia '91, New Haven  
 Allinson, M. J. C., Arkansas '45, New Haven  
 Alpert, M., Yale '28, Bridgeport  
 Alu, A. F., Yale '20, Ansonia  
 Amarant, L., Vienna '32, Bridgeport  
 Amatruda, F. G., Yale '23, New Haven  
 Ames, W. G., Columbia '38, Essex  
 Amos, I. L., McGill '26, Danbury  
 Amoss, H. L., Harvard '11, Greenwich  
 Anderson, C. W., Harvard '34, Greenwich  
 Andrews, E. M., Harvard '30, Hartford  
 Andrus, O. B., Univ. & Bellevue '32, Devon  
 Antell, M. J., Vermont '29, Bridgeport  
 Anton, M. C., Marquette '39, Stratford  
 Antupit, L., Jefferson '23, Hartford  
 Appell, H. S., Tufts '27, West Haven  
 Appell, P. H., Univ. & Bellevue '23, Bristol  
 Apsel, A., Long Island '18, Bridgeport  
 Apter, H., George Washington '34, Hartford  
 Apuzzo, A. A., Tufts '36, Bridgeport  
 Archambault, H. A., Tufts '27, Taftville  
 Arnold, H. B., Yale '26, New Haven  
 Arnold, H. S., Yale '03, Woodbridge  
 Arnold, M., Harvard '29, Willimantic  
 Arons, M. R., Maryland '30, Hartford  
 Arrick, M. S., Long Island '43, New Haven  
 Ashcroft, A. D., Columbia '35, Stratford  
 Ashley, H. C., Virginia '26, Winsted  
 Atha, H. G., Tufts '34, Thomaston  
 Atkins, S. M., Tufts '22, Waterbury  
 Audet, C. H., Maryland '17, Waterbury  
 Ayres, P. B., Toronto '32, Cos Cob  
 Backer, M., Yale '24, Bridgeport  
 Backhus, L. C., Syracuse '33, Waterbury  
 Bader, G. B., Columbia '20, Washington Depot  
 Backus, H. S., Long Island '03, Hartford  
 Bailey, N. H., P. & S., Balt. '11, Hartford  
 Baker, C. S., Yale '34, Willimantic  
 Baker, P. G., Vermont '33, Winsted  
 Bakunin, M. I., Jefferson '32, Bridgeport  
 Balletto, V., Tufts '33, East Haven  
 Banay, R. S., Budapest '20, New York City (New Haven County)  
 Bancroft, H. A., Albany '16, Hartford  
 Banks, D. T., Fordham '12, Bridgeport  
 Bannon, F. M., Vermont '28, Stamford  
 Barald, F. C., Boston '36, Jefferson Barracks, Mo. (New Haven County)  
 Barber, W. L., Jr., Univ. & Bellevue '07, Waterbury  
 Barber, R. R., Vermont '30, Stamford  
 Barbour, C. M., Jr., McGill '38, Hartford  
 Barbour, P. H., Jr., Yale '41, Farmington  
 Barker, C., Dartmouth '13, New Haven  
 Barker, D. C., Maryland '40, Fairfield  
 Barker, N. J., Toronto '26, Hartford  
 Barnes, F. H., N. Y. Homeo. '96, Stamford  
 Barney, W. E., Yale '35, Milford  
 Barnum, C. G., Yale '11, Groton  
 Barrett, W. J., Maryland '04, New Haven  
 Barry, J. C., Boston '33, Manchester  
 Barstow, R. I., Jefferson '33, Norfolk  
 Bartlett, C. J., Yale '95, New Haven  
 Barton, P. N., Harvard '39, Bristol  
 Basden, E. H., Tufts '33, Willimantic  
 Baskin, A. H., Minnesota '32, Elmwood  
 Bassin, A. L., Rochester '30, New Haven  
 Batelli, C. F., Yale '28, New Haven  
 Bates, D. H., Long Island '39, Putnam  
 Battista, A. W., Tufts '24, New Haven  
 Bausch, C. P., Tufts '29, Hartford  
 Bayne-Jones, S., Johns Hopkins '14, New York City (New Haven County)  
 Beach, C. C., Columbia '82, Hartford  
 Beach, C. T., Yale '05, Hartford  
 Beaman, G. B., Harvard '34, Stamford  
 Beardsley, L. G., Yale '17, Newington  
 Beatman, I., Tufts '27, Hartford  
 Beatrice, A. A., Tufts '29, Bristol  
 Beauchamp, M. F., Vermont '43, New Haven  
 Beauchemin, J. A., Montreal '25, Middletown  
 Beaudry, J. H., McGill '13, Bridgeport  
 Beck, E. C., Yale '26, South Norwalk  
 Beck, F. G., Yale '03, New Haven  
 Beck, S. H., Rochester '34, Bridgeport  
 Becker, J., Univ. & Bellevue '29, New London  
 Beckwith, D. M., Harvard '34, East Haven  
 Beebe, J. T., Columbia '38, Hartford  
 Behan, E. J., McGill '22, New Haven  
 Beizer, E., Long Island '30, Hartford  
 Bell, J. S., Illinois '28, Ridgefield  
 Bellew, R. F., Tufts '37, Bridgeport  
 Benedict, M. K., Johns Hopkins '19, New Haven  
 Benjamin, H. W., Rush '33, New Britain  
 Benoit, R. J., Georgetown '26, New Britain  
 Benton, P. E., Columbia '34, Stratford  
 Bergendahl, H. A., Tufts '33, Norwich  
 Bergin, T. J., Yale '99, Cos Cob

- Berlowe, M. L., Long Island '34, New Haven  
 Berman, B. A., Tufts '34, Waterbury  
 Berman, H. L., Yale '15, New Haven  
 Berne, E. L., McGill '35, Westport  
 Berneike, R. R., Western Reserve '41, New Haven  
 Bernstein, A., Yale '08, Bridgeport  
 Bernstein, D. J., Vermont '33, New Britain  
 Berwick, P., N. Y. Med. Coll. '38, Moodus  
 Besser, E. L., Johns Hopkins '37, Manchester  
 Bestor, E. L., N. Y. Homeo. '07, Hartford  
 Bevans, T. F., Minnesota '03, Waterbury  
 Bidgood, C. Y., Virginia '20, Hartford  
 Biehn, D. M. F., Queen's '37, Fairfield  
 Biehn, S. L., Toronto '26, Fairfield  
 Bielecki, C. E., Tufts '39, Norwich  
 Bienkowski, J. G., Harvard '35, Torrington  
 Bingham, C. T., Columbia '32, Hartford  
 Biondi, B., Tufts '38, New Haven  
 Biram, J. H., Cornell '10, West Hartford  
 Bird, F. S., Vermont '33, Bristol  
 Birge, H. L., Pennsylvania '33, Hartford  
 Birnbaum, H. B., Royal Coll. England '35, Madison  
 Birney, T. P., Northwestern '39, Bridgeport  
 Bishop, C. C., Yale '30, New Haven  
 Bissell, A. H., Cornell '16, Stamford  
 Bixby, H., Tufts '35, Bismarck, N. D., (Middlesex County)  
 Bizzozero, O. J., Vermont '27, Waterbury  
 Blaine, G. B., Jr., Columbia '43, South Kent  
 Blake, E. M., Yale '06, New Haven  
 Blake, F. G., Harvard '13, New Haven  
 Blanchard, D. L., Yale '31, Branford  
 Blank, E. H., Vermont '25, New London  
 Blass, G., Vienna '24, Stamford  
 Blau, R., Friedrich Wilhelms '20, Waterbury  
 Blinkoff, J. J., Berne '37, Torrington  
 Bliss, S. P., Tufts '39, Stratford  
 Blodinger, I. E., Yale '25, New Haven  
 Blogoslawski, W. J., Georgetown '27, New Britain  
 Bloom, D. I., Tufts '35, Thompsonville  
 Bloomberg, M., Tufts '24, Waterbury  
 Bluestone, D. H., Syracuse '12, Naugatuck  
 Blum, I., Geneva '35, Westport  
 Blumenthal, E. J., Long Island '32, Ansonia  
 Blumer, G., Cooper '91, Pasadena, California (New Haven County)  
 Boardman, A. K., Pennsylvania '99, New Haven  
 Bobrow, A., Berne '36, Hartford  
 Bodie, J. A., Tufts '24, New Haven  
 Bodie, W. J., Georgetown '29, New Haven  
 Bogin, M., Yale '26, Bridgeport  
 Boguniecki, S. J., Harvard '40, Meriden  
 Boisvert, P. L., Rochester '34, New Haven  
 Bonner, R. A., Maryland '12, Waterbury  
 Bonner, R. A., Jr., Maryland '38, Waterbury  
 Booc, J. G., Med. Coll. Va. '19, Bridgeport  
 Booth, J. D., Columbia '26, Danbury  
 Borkowski, B. J., Georgetown '28, Bristol  
 Bornemann, C., N. Y. Med. Coll. '40, Canaan  
 Botsford, C. P., Yale '94, Hartford  
 Bowen, F. D. T., Maryland '42, Hartford  
 Bowen, J. J., Jr., Maryland '41, Waterbury  
 Bowman, S. H., Hahnemann, Chicago '13, Stamford  
 Boyarsky, H. M., Tufts '31, Wallingford  
 Boyd, H., Harvard '21, South Manchester  
 Brackett, A. S., Jefferson '95, Bristol  
 Brackin, J. T., Jr., Penn. '36, Hines, Ill. (Hartford County)  
 Bradeen, F. B., Pennsylvania '99, Essex  
 Bradley, E. T., Cornell '36, New Canaan  
 Bradley, T. R., Maryland '14, South Norwalk  
 Brainard, C. B., Yale '98, West Hartford  
 Brandon, K. F., Toronto '32, Hartford  
 Branon, A. W., Jefferson '13, Hartford  
 Braun, R., Vienna '29, Bridgeport  
 Brayton, H. W., Harvard '11, Hartford  
 Breck, C. A., Yale '30, Wallingford  
 Brecker, F. W., Tufts '28, Hartford  
 Brennan, E. L., Natl. Univ., Ireland '23, Hartford  
 Brennan, P. J., Yale '07, Waterbury  
 Bretzfelder, K. B., Jefferson '16, New Haven  
 Brewer, A. E., N. Y. U. '41, Salisbury  
 Brewer, F., Columbia '20, Bloomfield (Fairfield County)  
 Brewer, T. F., Yale '26, Hartford  
 Brewster, W. B., Jr., Harvard '42, Hartford  
 Breyer, A., Vanderbilt '38, Houston, Texas (Hartford County)  
 Brezina, P. S., Yale '40, Bristol  
 Bria, W. F., Rome '34, Cos Cob  
 Bridge, J. L., Harvard '03, Hazardville  
 Brier, H. D., N. Y. U. '34, Bridgeport  
 Bristoll, D. A., Pennsylvania '27, New Britain  
 Brochu, E. D., Boston '33, Danbury  
 Brodsky, M. E., Northwestern '26, Bridgeport  
 Brody, B. S., Yale '28, New Haven  
 Brody, J., Tufts '39, New Haven  
 Bronson, W. T., University & Bellevue '98, Danbury  
 Brooks, P. L., McGill '32, Bridgeport  
 Brophy, E. J., Yale '04, Norwich  
 Brosnan, J. F., Tufts '30, New London  
 Brown, A. S., Yale '26, Waterbury  
 Brown, M. R. S., Temple '43, Meriden  
 Brown, P. H., Vermont '26, Stamford  
 Brown, W. T., Texas '33, Houston, Texas (New Haven County)  
 Browne, F. A., Johns Hopkins '20, Hartford  
 Bruckner, W. J., Cornell '33, New Haven  
 Bruno, J. J., Hahnemann '35, New Haven  
 Bruskin, C. E., Leipzig '32, Hartford  
 Bryan, K. M., Hering '04, Norwich  
 Buccheri, F. S., Tufts '35, New Britain  
 Bucciarelli, J. A., Temple '31, New Canaan  
 Buchan, R. F., McGill '42, West Hartford  
 Buck, B. J., Harvard '26, Hartford  
 Buckhout, G. A., Tufts '35, Bridgeport  
 Buckley, J. L., Tufts '40, Torrington  
 Buckley, R. C., Yale '24, Hartford  
 Buckley, J. W., Georgetown '33, Bridgeport  
 Buckley, W. E., Boston '33, Middletown  
 Buckmiller, F. C., Vermont '14, Bridgeport  
 Buda, G. E., Zurich '37, Stratford  
 Budau, J. H. D., Yale '00, Rockledge, Fla. (New Haven County)  
 Bull, J. N., Columbia '78, Plainville  
 Bumstead, J. H., Johns Hopkins '23, New Haven  
 Bunnell, W. W., Yale '29, Farmington  
 Bunting, H., Harvard '36, New Haven  
 Buol, R. S., Harvard '23, New Britain  
 Burack, J. O., Tufts '39, South Norwalk  
 Burgess, F. H., George Washington '40, Ridgefield  
 Burgdorf, A. L., Rush '31, Bloomfield  
 Burke, F. H., Georgetown '31, Rockville  
 Burke, J. F., Yale '31, Waterbury  
 Burlingame, C. C., Chicago '08, Hartford  
 Burness, S. H., Vermont '38, Hartford  
 Burns, B. J., Georgetown '18, Bridgeport  
 Burns, F. M., Columbia '39, Shelton  
 Burns, G. D., Yale '25, Derby



Burns, M. M., Texas '27, West Hartford  
 Butler, N. G., Tufts '24, Hartford  
 Byrne, D. W., Columbia '27, Hartford

Cabaniss, J. T., Columbia '15, Hartford  
 Cacace, V. A., Loyola '39, New Haven (Fairfield County)  
 Calabresi, M., Florence '26, New Haven  
 Caldwell, D. M., McGill '19, South Manchester  
 Calef, B., St. Louis '32, Elmwood  
 Calhoun, H. A. Tufts '34, Higganum  
 Callahan, J. W., P. & S., Balt. '11, Norwich  
 Callender, E. F., Yale '12, Chester  
 Calverley, E. T. T., Woman Med. Pa. '08, Hartford  
 Calvin, C. V., Harvard '16, Bridgeport  
 Cammann, O. DeN., Columbia '33, New Canaan  
 Campbell, H. B., Pennsylvania '09, Norwich  
 Campbell, R. H., Wayne '35, West Hartford  
 Campbell, S., Vermont '23, Wallingford  
 Canby, J. E., Jefferson '27, West Hartford  
 Caney, W. H., Albany '41, Watertown  
 Canfield, N., Michigan '29, New Haven  
 Capacelatro, A., Tufts '19, New Haven  
 Caplan, H., Yale '27, Meriden  
 Caplan, M., Louisville '33, Meriden  
 Capobianco, A. P., N. Y. Med. Coll. '40, Bridgeport  
 Cappiello, S., Tufts '19, Hartford  
 Carbone, W. C., Georgetown '33, Hamden  
 Cardone, M. J., Vermont '37, Bridgeport  
 Carelli, G. F., Yale '11, New Haven  
 Carey, T. C., Yale '28, Hartford  
 Carey, W. C., Columbia '33, Meriden  
 Carignan, R. Z., Georgetown '40, East Hartford  
 Carlin, C. H., Michigan '96, Torrington  
 Carlson, R. I., Yale '39, New Haven  
 Carniglia, E. F., Harvard '29, Hartford  
 Carpenter, R. M., Loyola '16, Stamford  
 Carpentieri, A. L., N. Y. Med. Coll. '38, Waterbury  
 Carpinella, M. J., Rochester '32, Branford  
 Carroll, F. P., Johns Hopkins '14, Bridgeport  
 Carroll, J. E., Boston '25, Hartford  
 Carroll, P. R., Jr., Georgetown '29, Bridgeport  
 Carroll, W. E., Dartmouth '14, Orange, N. J. (New Haven County)

Carrozzella, J. C., Long Island '28, Wallingford  
 Carter, E. B., Johns Hopkins '11, Hartford  
 Carter, G., Johns Hopkins '28, Greenwich  
 Carter, G. H., Columbia '35, Willimantic  
 Carvey, E. V., Yale '35, Wethersfield  
 Carwin, J. L., Meharry '32, Stamford  
 Casagrande, J. J., St. Louis '32, Ansonia  
 Case, E. P., Michigan '11, West Hartford  
 Case-Downer, M., Boston '29, Hartford  
 Caserta, S. J., Georgetown '37, Bridgeport  
 Cashman, J. L., Hahnemann '37, North Haven  
 Cassone, R., Vermont '41, Stamford  
 Castaldo, L. F., Tufts '37, Bridgeport  
 Castiglione, F. M., N. Y. Med. Coll. '42, New Haven  
 Caulfield, E. J., Johns Hopkins '20, Hartford  
 Celentano, L. E. H., Hahnemann '30, New Haven  
 Cenci, V. P., Tufts '29, Hartford  
 Centrone, P. A., Columbia '37, New Haven  
 Cerrone, L. J., Bologna '38, New Haven  
 Chaffee, J. S., Pennsylvania '97, Sharon  
 Chait, S. A., Nebraska '40, Torrington  
 Chapnick, M. H., Jefferson '32, Putnam  
 Chartier, G. M., Boston '33, Danielson  
 Chase, A. A., Harvard '01, Plainfield  
 Chase, C. C., Vermont '24, Middletown  
 Chasnoff, J. A., Long Island '36, West Haven

Chaucer, N. G., Columbia '41, Stamford (New Haven County)  
 Cheney, C. B., Yale '41, New Haven  
 Cheney, G. P., Md. Coll. Med. '13, New London  
 Cheney, M. L., Vermont '17, Bridgeport  
 Chernaik, S. J., Jefferson '16, New Britain  
 Chester, L. L., Vermont '38, Hartford  
 Childs, A. E., University & Bellevue '96, Stanfield, Oregon (Litchfield County)  
 Chobian, J. A., Loyola, '33, Seymour  
 Chou, T. P., Hunan-Yale '22, Stamford  
 Ciccarelli, A. W., Hahnemann '42, Bristol  
 Cipriano, A. P., Long Island '41, New Haven  
 Claiborn, L. N., Washington '27, New Haven  
 Clancy, J. J., Yale '35, Hartford  
 Claps, L. V., N. Y. U. '40, Greenwich  
 Clark, B. B., Cornell '37, New Britain  
 Clark, M. H., Women's Medical '33, New Haven  
 Clark, W. T., Queen's '34, Bridgeport  
 Clarke, C. C., Yale '32, New Haven  
 Clarke, H. M., Rochester '39, New Britain  
 Clarke, R. DeB., Johns Hopkins '08, Hartford  
 Clarke, W. I., Harvard '41, Meriden  
 Clason, F. P., Harvard '15, Hartford  
 Cleary, H. J., Tufts '29, Watertown  
 Clement, D. H., Harvard '35, New Haven  
 Clifford, M. L., Colorado '33, Hartford  
 Clifton, H. C., Pennsylvania '01, Bloomfield  
 Clinan, M., Columbia '15, Hartford  
 Climo, S., Ohio '29, New Haven  
 Close, J. F., Columbia '25, Greenwich  
 Clow, H. L., Tufts '14, Newtown  
 Coates, S. P., Maryland '34, Suffield  
 Cobb, A. E., Yale '98, Canaan (Hartford County)  
 Cobey, J. F., Yale '16, New Haven  
 Cody, G. R., Georgetown '36, South Norwalk  
 Cody, T. P., Long Island '36, New Canaan  
 Coffey, J. R., Yale '07, New Haven  
 Cofrances, L. W., Jefferson '23, New Haven  
 Cogan, G. E., Georgetown '23, Hartford  
 Cogland, J. L., Vermont '34, Rochester, N. Y. (Hartford County)

Cognetta, J. J., Vermont '36, Stamford  
 Cogswell, E. S., Harvard '12, Hartford  
 Cogswell, L. P., Harvard '33, Hartford  
 Cohane, T. F., Yale '97, New Haven  
 Cohen, D. J., Yale '32, Meriden  
 Cohen, L. H., Yale '31, New Haven  
 Cohen, W., Yale '23, New Haven  
 Cohn, S. H., Boston '34, Hartford  
 Colburn, R. F., Vermont '37, Stamford  
 Cole, C. H., Yale '32, Waterbury  
 Colett, I. V., Vienna '38, Norwich  
 Collins, J. O., Baylor '29, Waterbury  
 Collins, W. F., Yale '04, New Haven  
 Colmers, R. A., Vienna '37, Stamford  
 Colwell, H. S., Johns Hopkins, '14, New Haven  
 Combes, J. DeR., Long Island '17, Salisbury  
 Comfort, C. W., Jr., Yale '11, New Haven  
 Compson, F. E. M., Boston '20, Middletown  
 Comstock, E. R., Tufts '33, New London  
 Conklin, C. S., Fordham '16, Bridgeport  
 Conklin, C. T., Jr., Vermont '41, Thomaston  
 Conlon, W. L., Jefferson '36, Manchester  
 Conner, E. D., Long Island '43, Fairfield  
 Connolly, A. J., Georgetown '28, New Haven  
 Connolly, J. P., Georgetown '36, Stamford  
 Connor, G. M., Boston '35, Plantsville  
 Connor, J. J., Yale '30, Hartford

- Connors, E. R., Boston '31, Bridgeport  
 Conroy, M. J., Yale '20, Meriden  
 Conte, H. A., Long Island '12, New Haven  
 Conte, M. G., Naples '35, New Haven  
 Converse, F. B., Eclectic, Cinn. '94, West Willington  
 Conway, D. F., Jr., Columbia '37, New Haven  
 Cook, G. F., Tufts '23, Plainville  
 Cook, R. J., Johns Hopkins '13, New Haven  
 Cooley, C. M., Yale '08, New Britain  
 Coppeto, C. J., Marquette '39, Waterbury  
 Coppola, E. A., Long Island '10, Waterford  
 Corbett, H. J., Tufts '29, Waterbury  
 Corbett, W. T., Hahnemann '42, Long Hill  
 Corcoran, M. A., Tufts '30, Hartford  
 Corey, W. VanA., George Washington '33, Hamden  
 Cornelio, F. J., Georgetown '34, Winsted  
 Cornwell, P. M., Yale '34, Hartford  
 Corradino, C. L., Tufts '29, New Haven  
 Corridon, J. D., Georgetown '28, South Norwalk  
 Corwin, D. B., Syracuse '32, Norwalk  
 Coshak, M., Boston '37, Waterbury  
 Costanzo, J. J., Illinois '05, Stamford  
 Costello, H. N., Johns Hopkins '10, Hartford  
 Cotterio, T., Yale '26, Waterbury  
 Couch, F. H., Yale '30, Cromwell  
 Couch, M. W., Minnesota '27, Cromwell  
 Couture, A. J., Boston '32, Moosup  
 Cox, M. E., Cincinnati '36, Waterbury  
 Cox, R. B., McGill '02, Collinsville  
 Coyle, B. J., Georgetown '18, Windsor Locks  
 Cozzolino, E. N., Harvard '33, West Haven  
 Craig, G. M., Harvard '20, Middletown  
 Craighill, M. D., Johns Hopkins '24, Topeka, Kansas  
 (Fairfield County)  
 Cramer, S. L., N. Y. Medical '41, New Haven  
 Crampton, C. B., Yale '37, Middletown  
 Crandall, B. B., Wisconsin '34, Mystic  
 Crane, J. E., Vermont '39, Stamford  
 Crane, R. W., Yale '05, Stamford  
 Crawley, G. A., Temple '28, West Hartford  
 Creadick, A. N., Pennsylvania '08, New Haven  
 Creaturo, N. E., Boston '31, Bridgeport  
 Cressy, N. L., Yale '39, Newington (New Haven County)  
 Crispell, L. S., Yale '44, Bridgeport (New Haven County)  
 Crispin, M. A., Temple '41, Bridgeport  
 Crosby, E. H., Yale '28, Hartford  
 Cullen, J. R., Georgetown '36, Hartford  
 Culotta, C. S., Yale '28, New Haven  
 Cunningham, J. M., Texas '26, Hartford  
 Cunningham, R. D. M., Yale '30, Stamford  
 Curley, W. H., Cornell '08, Bridgeport  
 Curley, W. H., Jr., Cornell '38, Bridgeport  
 Curnen, E. C., Jr., Harvard '35, New Haven  
 Curran, H. J., Tufts '24, Waterbury  
 Curran, P. J., Columbia '01, Bridgeport  
 Curran, T. L., Boston U. '39, Hartford  
 Curtis, A. K., Tufts '05, East Hartford (Windham County)  
 Curtis, B. H., Columbia '36, Hartford  
 Curtis, W. B., Columbia '34, New Haven  
 Cushman, L. A., Harvard '24, West Hartford  
 Cutler, H. S., St. Louis '37, New Haven  
 D'Alessio, C. M., Maryland '37, Derby  
 Daley, L. W., McGill '30, New Britain  
 Dallas, M., Boston '22, New Haven  
 Dalton, G. H., Yale '12, New Britain  
 Daly, C. W., P. & S., Balt. '10, Hartford  
 Daly, J. L., N. Y. U. '33, Norwich  
 Daly, W. P., Georgetown '17, Hartford  
 D'Ambruso, D. C., Columbia '36, Derby  
 Damiani, R. A., Tufts '33, Waterbury  
 D'Amico, J., Rome '37, New Haven  
 D'Amico, M., Yale '31, New Haven  
 Danaher, T. J., Yale '28, Torrington  
 Danburg, D. S., Louisville '39, Norwich  
 D'Andrea, F. H., Yale '29, Stamford  
 Danowski, T. S., Yale '40, New Haven  
 Darrow, D. C., Johns Hopkins '20, New Haven  
 Darrow, J. E., Tufts '28, New Britain  
 Dart, F. B., Maryland '23, Niantic  
 Dautrich, A. W., Yale '39, Litchfield  
 Davenport, A. K. P., South Carolina '03, Hartford  
 Davis, D. A., Hahnemann '36, Derby  
 Davis, G. B., Vermont '24, Milford  
 Davis, J. B., Kansas '33, New Haven  
 Davis, J. E., Johns Hopkins '19, Hartford  
 Davis, J. S., Boston U. '36, South Norwalk  
 Davis, T. F., Tufts '21, Fairfield  
 Davol, R. T., Columbia '41, Greenwich  
 Dawson, L. M., Queen's '09, Unionville  
 Day, F. L., Bellevue '93, Bridgeport  
 Day, H. L., Yale '34, New Haven  
 Dayton, A. B., Johns Hopkins '15, New Haven  
 Dayton, N. A., Ohio '15, Mansfield Depot (Windham County)  
 Dayton, T. R., Harvard '25, Wallingford  
 Dean, S. R., Michigan '34, Stamford  
 DeAngelis, L., Virginia '36, New London  
 DeBonis, D. A., Naples '90, Hartford  
 DeCristoforo, R., Tufts '37, Waterbury  
 DeForest, G. K., Yale '32, New Haven  
 DeKlyn, W. B., Temple '41, Danbury  
 de la Vergne, P. M., McGill '35, Meriden  
 Delevett, A. F., Johns Hopkins '40, Bridgeport  
 Delligan, F. W., Georgetown '41, Hartford  
 Delohery, C. L., Temple '26, Danbury  
 DeLuca, H. R., George Washington '16, Bridgeport  
 DelVecchio, L. F., Georgetown '31, Bridgeport  
 Deming, C. D., Johns Hopkins '10, Hartford  
 Deming, C. K., Columbia '17, New Haven  
 Deming, C. L., Yale '15, New Haven  
 Deming, E. A., Johns Hopkins '08, Hartford  
 Deming, N. L., Columbia '93, Old Saybrook  
 Denne, T. H., Vermont '05, West Hartford  
 Dennehy, W. J., Yale '18, New Haven  
 DePasquale, F. L., Pennsylvania '26, Hartford  
 DePasquale, J. A., Pennsylvania '36, Hartford  
 Deren, M. D., Syracuse '33, Bridgeport  
 DeRosa, S. F., Jefferson '24, Meriden  
 Desmond, C. T., Boston U. '38, Hartford  
 Desmond, W. F., Yale '25, Newtown  
 D'Esopo, J. N., McGill '31, New Haven  
 de Suto-Nagy, I. K., Royal Hung. '15, New Haven  
 DeTora, A. M., Boston U. '40, Middletown  
 Deutsch, J. V., Long Island '36, Southbury  
 DeVito, M. J., Vanderbilt '28, Hartford  
 Devitt, E. K., Maryland '07, Old Lyme  
 DeWitt, E. N., Pennsylvania '17, Bridgeport  
 Diamond, E. H., Breslau '32, Norwalk  
 Dichter, C. L., Md. Coll. Med. '05, Stamford  
 Dichter, I. S., Jefferson '31, Stamford  
 Dickinson, F. McL., Columbia '05, Rockville  
 DiFrancesco, L. P., Tufts '31, Stamford  
 DiGandomenico, A. T., St. Louis '41, Meriden  
 Dignam, B. S., Yale '35, Thompsonville  
 Dillon, J. H., Yale '04, Waterbury  
 Dinan, H. P., Tufts '38, Stratford  
 Dinolt, R., Vienna '30, Putnam  
 Dinsmore, W. W., Johns Hopkins '07, Hartford



- Dion, A. J., Tufts '28, Hartford  
Dion, J. A., Georgetown '37, Hartford  
Dionne, U. A., Tufts '30, Waterbury  
Diskan, A. E., Temple '37, Manchester  
DiStasio, F., Maryland '33, New Haven  
Dixon, H. C., Bowdoin '17, Norwich  
Dobbs, W. G. H., Rochester '34, Torrington  
Dobkins, J. J., Toronto '39, Stamford  
Dodd, B., Columbia '33, Hartford  
Doerr, W. J., Erlangen '40, Hartford  
Doff, S. D., Long Island '39, New Haven  
Dolce, J. A., South Carolina '25, Hartford  
Donadeo, J., Bologna '42, Bridgeport  
Donnelly, S. P., Georgetown '24, New Britain  
Donnelly, W. A., Cornell '40, Bridgeport  
Donner, S., Cornell '33, Hartford  
Donohue, B. F., Yale '03, Bristol  
Donohue, J. D., Baltimore '09, Uncasville  
Donohue, J. J., P. & S., Balt. '96, Norwich  
Donovan, W. F., Boston '31, Hartford  
Dorian, G. D., Hahnemann '39, New Britain  
Dorian, N. E., Maryland '17, New Britain  
Dorion, R. H., Vermont '32, Stamford  
Douglass, E. L., Long Island '16, Groton  
Downs, E. F., Johns Hopkins '37, Bronxville, N. Y. (Litchfield County)  
Dray, E. J., Jefferson '09, New Britain  
Dreher, A. C., Yale '23, Waterbury  
Dreher, S. M., Temple '37, Derby  
Driscoll, J. J., Vermont '25, Danbury  
Driscoll, W. T., P. & S., Balt. '12, Norwich  
Drobnes, S., Freiburg '37, Norwich  
DuBois, F. S., Rush '31, New Canaan  
DuBois, R. L., Maryland '35, Waterbury  
Dudac, T. W., Georgetown '33, Southington  
Duffy, L. T., Tufts '34, Hartford  
Duffy, V. P., Maryland '17, Naugatuck  
Duffy, W. C., Johns Hopkins '14, New Haven  
Duksa, W. J., Georgetown '37, Hartford  
Dunham, E. C., Johns Hopkins '18, Washington, D. C. (New Haven County)  
Dunn, F. M., Baltimore '08, New London  
Dunn, G. W., Baltimore '09, New Britain  
Dunne, E. P., Maryland '18, Unionville  
Durkee, R. E., Jr., Harvard '36, Hartford  
Durlacher, S. H., Yale '38, New Haven  
Dushane, J. E., Tufts '36, Hartford  
Duzmati, P. P., Jefferson '36, Bridgeport  
Dwyer, C. E., Georgetown '25, Waterbury  
Dwyer, P. J., University & Bellevue '97, Waterbury  
Dwyer, W., Johns Hopkins '13, Hartford  
Dyer, C. E., Tufts '28, New London  
Earle, B. B., Rush '30, Glastonbury  
Ebers, T. M., Nebraska '31, Hartford  
Eckert, G. R., Tufts '33, Danbury  
Eddy, M. H., Harvard '35, Bridgeport  
Edgar, K. J., Oregon '31, Bridgeport  
Edlin, C., Tufts '25, Waterbury  
Edson, D. H., Vermont '42, Danbury  
Edson, R. C., Jefferson '31, Hartford  
Edson, R. H., Cornell '35, Shelton  
Egan, J. J., Maryland '07, Newington (New Haven County)  
Egee, J. B., Hahnemann '34, Newtown  
Eimas, A., Tufts '30, Bridgeport  
Eisenberg, S. E., Rochester '39, New Britain  
Eliot, M. M., Johns Hopkins '18, Washington, D. C. (New Haven County)  
Elkinton, J. R., Harvard '37, Hamden  
Elliot, K. G., Tufts '26, Hartford  
Elliott, J. R., Boston '32, Canaan  
Ellis, F. D., Jr., Pennsylvania '18, New Britain  
Ellis, L. G., Jefferson '20, Hartford  
Ellison, F. S., Yale '34, Hartford  
Ellrich, D. L., Jefferson '28, Westport  
Elmer, E. O., P. & S., Balt. '94, Hartford  
Elsberg, C. P., N. Y. Med. Coll. '33, New Britain  
Ely, J. G., Harvard '23, Lyme  
Ematrudo, F. R., Eclectic, Cinn. '21, Hamden  
Emmett, F. A., Yale '02, Hartford  
Enander, F. C., Tufts '22, New Britain  
English, C. F., St. Louis '12, Winsted  
Englehart, E. E., Strassburg '17, Hartford  
Epstein, B., Vienna '36, Danbury  
Epstein, C. J., Yale '29, New Haven  
Errico, L., Yale '21, New Haven  
Eskvith, I. S., Syracuse '40, Bridgeport  
Esposito, J. J., Columbia '37, Bridgeport  
Etkind, M. G., Maryland '33, New Haven  
Evans, J. H., Boston U. '02, New Haven  
Evans, T. S., Columbia '21, New Haven  
Evarts, J., Columbia '29, Cornwall Bridge  
Eveleth, M. S., Johns Hopkins '38, New Haven  
Ewell, J. W., Harvard '36, New Haven (Hartford County)  
Fabricant, S. E., Jefferson '19, Waterbury  
Fabro, J. A., Tufts '37, Torrington  
Fagan, F. X., Cornell '33, Hartford  
Farland, V. L., Montreal '25, Hartford  
Farquhar, L. R., Yale '37, Avon  
Fawcett, G. G., Cornell '15, South Norwalk  
Fay, W. J., Harvard '14, Hartford  
Feeney, T. M., Boston '36, Hartford  
Fekety, S. H., Tufts '30, Middletown  
Felding, H. A., Hahnemann '31, Stamford  
Felt, P. R., Dartmouth '10, East Hampton  
Felty, A. R., Johns Hopkins '20, Hartford  
Fenney, P. W., Tufts '31, New Haven  
Ferguson, H. K., N. Y. U. '32, New London  
Ferguson, J. F., Jr., Yale '40, Wallingford  
Ferguson, R. C., Yale '20, Rockville  
Ferrara, M., Marquette '35, Norwich  
Filson, R. M., Queen's '15, West Hartford  
Fincke, C. L., Harvard '28, Stamford  
Findorak, F. G., Georgetown '37, Bridgeport  
Fine, B., Jefferson '32, Stamford  
Fine, J., Pennsylvania '31, Stamford  
Finesilver, E. M., Johns Hopkins '24, Hartford  
Fink, L., Leipzig '23, Bridgeport  
Finkelstein, W., Harvard '34, Waterbury  
Finkelstone, B. B., P. & S., Balt. '10, Bridgeport  
Finley, G. C., Tufts '24, Hartford  
Finn, A. J., Bowdoin '21, Waterbury  
Finn, E. J., Yale '10, Shelton  
Fiorito, J. A., Washington '37, New Haven  
Firestone, S. D., Lausanne '34, Rockville  
Fischer, A., Paris '36, Hamden  
Fischer, W. J. H., Yale '11, Milford  
Fisher, J. G., Paris '11, Greenwich  
Fisher, J. W., Wom. Med. Pa. '93, Middletown  
Fiske, M., Boston '27, Stamford  
Fiskio, P. W., Yale '27, New Haven  
Fitzpatrick, E. E., Maryland '15, Waterbury  
Fitzpatrick, W. F., Cornell '38, Norwalk  
FitzSimons, E. F., Tufts '24, New Haven  
Flaherty, C. V., Yale '10, Hartford  
Flaherty, J. E., Georgetown '08, Rockville  
Flanagan, E. D., St. Louis '35, South Norwalk

- Fleck, H. W., Jefferson '96, Stratford  
 Fleish, M. C., Tufts '40, Hartford  
 Flynn, C. T., Yale '11, New Haven  
 Flynn, H. A., Yale '27, New Haven  
 Flynn, H. L., Vermont '29, Mansfield Depot (Tolland County)  
 Flynn, W. H., Maryland '16, Bristol  
 Foley, F. X., Boston '34, Bridgeport  
 Foord, A., Columbia '41, New Haven  
 Foote, C. J., Harvard '87, New Haven  
 Ford, A. P., Wom. Med. Pa. '04, New Haven  
 Foster, E. W., Harvard '24, Meriden  
 Foster, H. J., Hahnemann '43, Berlin  
 Foster, J. H., Pennsylvania '17, Waterbury  
 Foster, L. C., Harvard '23, New Haven  
 Fowler, R. N., Columbia '34, Mystic  
 Fox, G. F., Vermont '37, Hartford  
 Fox, G. G., Harvard '34, Meriden  
 Fox, J. C., Jr., Johns Hopkins '20, Hartford (New Haven County)  
 Fox, R. A., Creighton '37, Danbury  
 Frank, H. S., Columbia '24, Middletown  
 Frazer, J. P., Rochester '39, Rochester, N. Y. (New Haven County)  
 Freedman, B. P., Yale '20, New Haven  
 Freeman, A. C., Vermont '13, Norwich  
 Freeman, D., Yale '24, New Haven  
 Freeman, J. J., Temple '33, Newington  
 Freiheit, J. M., Yale '27, Waterbury  
 Friedberg, I. H., Tufts '37, Newington  
 Friedberg, S., Long Island '28, Stamford  
 Friedman, E., Buffalo '34, Norwich  
 Friedman, I., George Washington '31, Colchester  
 Friedman, I., Yale '33, New Haven  
 Friedman, N. H., Tufts '33, Stratford  
 Friedman, S., Boston '31, Newtown  
 Friend, A. E., Queen's '22, South Manchester  
 Friery, C. M., Boston '29, Hartford  
 Friesen, A. R., Nebraska '44, Philadelphia, Penn. (New Haven County)  
 Fritz, J., Vienna '15, Hartford  
 Frost, L. H., Vermont '13, Plainville  
 Frothingham, J. G., Harvard '35, New Canaan  
 Fry, C. C., Northwestern '24, New Haven  
 Fuldner, R. V., Columbia '33, New Haven  
 Fuller, R. H., Tufts '38, Simsbury  
 Funkhouser, S. P., Washington U. '19, Winsted  
 Furniss, H. W., Howard '91, Hartford  
 Gaberman, D., Columbia '20, Hartford  
 Gade, C. J., Yale '10, Bridgeport  
 Gaetz, T. H., McGill '24, Shelton  
 Gaffney, C. B., Loyola '30, Bridgeport  
 Gaffney, J. J., Loyola '30, Danbury  
 Galen, J. H., Long Island '42, Ansonia  
 Galinsky, D., Tufts '35, Hartford  
 Gallivan, J. N., Tufts '35, East Hartford  
 Gallo, F., Jefferson '34, Winsted  
 Gallo, W. J., Columbia '33, Pass-a-Grille, Fla. (Hartford County)  
 Gancher, J., Long Island '06, Waterbury  
 Gandy, R. A., Virginia '27, Stamford  
 Gandy, R. R., Pennsylvania '99, Stamford  
 Ganey, J. M., Columbia '04, New London  
 Garbelnick, D. A., Boston '17, Bridgeport  
 Garcin, C. R., McGill '25, Danielson  
 Gardner, C. W., Maryland '01, Bridgeport  
 Gardner, H. T., Yale '41, New York City (New Haven County)  
 Gardner, N. H., Tufts '34, East Hampton  
 Gardy, L. A., Bologna '37, Hartford  
 Garland, R. B., P. & S., Balt. '13, Hartford  
 Glick, G. B., Yale '12, Bridgeport  
 Grimaldi, M. L., Naples '35, New Haven  
 Garston, L. E., St. Louis '30, Torrington  
 Gates, A. B., Long Island '12, Greenwich  
 Gaylord, C. W., Yale '15, Branford  
 Geck, O. F., Munich '25, Hartford (Middlesex County)  
 Geer, W. A., Yale '34, Bridgeport  
 Geetter, I. S., Jefferson '29, Hartford  
 Geib, H. A., Univ. & Bellevue '14, Milford  
 Geiger, A. J., Harvard '30, New Haven  
 Gencarelli, A. F., Buffalo '39, New Haven  
 Gendel, B. R., Tulane '35, Memphis, Tenn. (New Haven County)  
 Genovese, F. T., N. Y. U. '29, Danbury  
 Genovese, S., Cornell '11, Danbury  
 Gens, J. P., Yale '37, Norwalk  
 Gentile, A. L., Boston '29, New Haven  
 Geraci, L. A., Columbia '17, New Haven  
 German, W. J., Harvard '26, New Haven  
 Gerow, G. H., Toronto '24, Westport  
 Gerstl, B., Vienna '27, New Haven  
 Gesell, A., Yale '15, New Haven  
 Gettings, J. A., Jefferson '16, New Haven  
 Giamarino, H. J., Maine '06, New Haven  
 Giannotti, C. C., Albany '18, West Haven  
 Gibson, C. B., Atlanta '14, Meriden  
 Gibson, D. F., Yale '27, Danbury  
 Gibson, F. D., Syracuse '35, Hartford  
 Giddings, J. C., Vermont '43, Meriden  
 Giffin, L. A., Harvard '35, Hartford  
 Gilday, J. L., Eclectic, Cinn. '13, Bridgeport  
 Gildea, M. A., Buffalo '24, Bridgeport  
 Gildersleeve, C. C., Yale '96, Norwich  
 Gildersleeve, G. H., Yale '23, Norwich  
 Giles, N. W., Vermont '21, Stamford  
 Gill, M. H., Yale '96, Hartford  
 Gillespie, H., Jefferson '34, Hartford  
 Gillette, A. T., Cornell '08, Woodbury  
 Gillis, G. E., Tufts '37, North Haven  
 Gills, W. L., Johns Hopkins '12, Hartford  
 Gillson, R. E., Vermont '29, New Haven  
 Gilman, R. L., Harvard '29, Storrs (Windham County)  
 Gilmer, R. J., McHarry '42, New Haven  
 Gilmore, H. R., Yale '31, Hamden  
 Gilmore, J. L., Yale, '04, West Haven  
 Giobbe M. E., Tufts '29, Torrington  
 Giorgio, N. A., Long Island '25, Hartford  
 Gipstein, E., Jefferson '31, New London  
 Girouard, J. A., Baltimore '99, Willimantic  
 Gissler, N. E., Yale '28, Middletown  
 Giuffrida, F., Tufts '37, Meriden  
 Giuliano, L. A., Tufts '32, South Norwalk  
 Giuliano, S., Tufts '30, Hartford  
 Glass, G. C., Yale '31, Hartford  
 Glass, W. H., Duke '37, Hartford  
 Glaubman, H. M., Yale '27, Hartford  
 Glazer, M., Tulane '22, New Haven  
 Glazier, J. R., Harvard '22, West Hartford  
 Glike, F. P., Yale '41, Meriden  
 Glorig, A., Jr., Med. Evang. '37, New Haven  
 Goddard, H. B., Harvard '24, East Hartford  
 Godfrey, E. J., Georgetown '15, Waterbury  
 Godfrey, E. W., Pennsylvania '37, Hartford  
 Godfried, M. S., Yale '36, New Haven  
 Goff, C. W., Illinois '24, Hartford  
 Gold, J. D., Columbia '91, Bridgeport



- Gold, L. H., N. Y. Med. '32, Hartford  
 Goldberg, I. S., Creighton '33, Torrington  
 Goldberg, S. J., Yale '07, New Haven  
 Goldberg, S. J., Jr., Harvard '36, New Haven  
 Goldenberg, J. J., Dalhousie '26, Hartford  
 Goldman, G., Yale '10, New Haven  
 Goldmeier, E., Frankfurt '39, Groton  
 Goldschmidt, M., Med. Coll. of Virginia '38, New Britain  
 Goldstein, M., Yale '24, New Haven  
 Goldstein, M. R., Hahnemann '43, Hartford  
 Goldys, F. M., Tufts '26, Danbury  
 Golino, E. F., Rochester '36, Hartford  
 Golomb, E. F., Woman's Med. Pa. '38, Bridgeport  
 Golston, H., Med. Coll. of Virginia '26, Hartford  
 Gompertz, M. L., Columbia '37, New Haven  
 Good, W. M., Yale '09, Waterbury  
 Goodell, R. A., Harvard '28, Hartford  
 Goodrich, C. A., Columbia '06, Hartford  
 Goodrich, W. A., Columbia '35, Hartford (New Haven County)  
 Goodrich, W. J., Albany '39, Bridgeport  
 Gordon, W. F., Long Island '06, Danbury  
 Gore, M. A., Maryland '18, Granby, Colo. (Hartford County)  
 Gorham, G. V., Michigan '30, Norwalk  
 Gosselin, G. A., Vermont '15, Hartford  
 Gottesfeld, B. H., Colorado '39, Hartford  
 Gould, L. N., N. Y. Med. Coll. '27, Norwich  
 Gould, M. M., Tufts '31, Hartford  
 Gourlie, H. W., Harvard '31, Thompsonville  
 Grady, J. F., Columbia '32, New Haven  
 Granniss, I., Yale '06, Old Saybrook  
 Granoff, M. A., Chicago '37, New Haven  
 Grant, A. S., Univ. & Bellevue '08, New Britain  
 Grant, R. F., Albany '38, Cromwell  
 Gratz, C. M., Toronto '23, Greenwich  
 Grau, L. C., Dartmouth '12, Hartford  
 Gray, A. S., University & Bellevue '15, West Hartford  
 Gray, H. J., St. Louis '21, Hartford  
 Grayson, M., N. Y. Med. Coll. '41, New London  
 Green, H. H., Johns Hopkins '31, South Norwalk  
 Green, J. H., Univ. & Bellevue '13, Waterbury  
 Green, W. F., Harvard '32, Newtown  
 Greenberg, A., Long Island '32, Old Saybrook  
 Greenblatt, H. J., Vermont '36, New Britain  
 Greenblatt, J., Louisiana '39, Stamford  
 Greene, G. G., Harvard '39, Boston, Mass. (Hartford County)  
 Greenhouse, B., Yale '21, New Haven  
 Greenspun, D. S., Yale '25, Bridgeport  
 Greenstein, C. J., Baltimore '12, New Britain  
 Greiner, G. F., Vanderbilt '40, Kent  
 Grendon, D. A., Harvard '28, Kent  
 Grenon, O. A., Georgetown '33, East Haven  
 Griffin, D. P., Jefferson '14, Bridgeport  
 Grigas, J. E., Tufts '36, Greenwich  
 Griggs, J. B., Yale '26, West Hartford  
 Grillo, V. J., Yale '33, New York City (New Haven County)  
 Grillo, W., Rochester '38, Waterbury  
 Grimm, H. W., Jefferson '16, Fairfield  
 Griswold, A. S., Yale '21, Bridgeport  
 Griswold, C., Yale '24, Bridgeport  
 Griswold, E. M., Yale '32, Glastonbury  
 Griswold, M., Yale '25, New Haven (New London County)  
 Griswold, M. H., Vermont '13, Hartford  
 Griswold, M. T., Tufts '05, Harwinton  
 Groark, J. A., Yale '24, New Haven  
 Groark, O. J., Med. Chi. Phila. '16, Bridgeport  
 Grodin, H. W., Yale '17, New Haven  
 Grossman, J. H., Rochester '41, Bridgeport  
 Grossman, W., Berlin '21, Hartford  
 Grosvenor, F. L., Buffalo '00, Hartford  
 Grout, S. P., Vermont '04, Newtown  
 Grower, J. H., Nebraska '25, Middletown  
 Gudernatch, G. S., Cornell '39, Sharon  
 Guida, F. P., Yale '34, New Haven  
 Gulash, J. R., Marquette '40, Bridgeport  
 Gulino, A. J., Tufts '31, Plainfield  
 Gura, G. M., Loyola '31, Southington  
 Gurwitz, J., Tufts '38, Newington  
 Gushee, E. S., Harvard '03, Wallingford  
 Guthrie, R. H., Tennessee '21, Norwich  
 Haberlin, C. E., Med. Coll. Va., '24 Stratford  
 Haddad, F. M., Yale '43, Ansonia  
 Haines, H. L., Johns Hopkins '39, New London  
 Hale, F., Columbia '09, Bridgeport  
 Hale, V. A., Texas '22, Norwich  
 Haliday, E. G., Queen's '27, Stonington  
 Hall, L., Harvard '24, Hartford  
 Hall, M. I., Edinburgh '34, Bristol  
 Hall, R. W., Yale '07, Bridgeport  
 Hall, W. C., Pennsylvania '30, Hartford  
 Hall, W. E., Yale '25, Meriden  
 Halloran, J. V., Boston U. '36, Greenwich  
 Hamilton, J. S. M., McGill '26, Stamford  
 Hamlin, C. H., Harvard '41, Boston, Mass. (Hartford County)  
 Hanchett, H. B., Jefferson '05, Torrington  
 Hankin, M. A., Long Island '33, New Haven  
 Hanley, J. B., Jefferson '39, Bristol  
 Hanley, J. L., Jr., Yale '35, Bridgeport  
 Hanley, J. P., Cornell '06, Stafford Springs  
 Hanrahan, W. R., P. & S., Balt. '05, Bristol  
 Hansell, R. J., Ohio '32, Greenwich  
 Hanson, M. C., Rush '23, Waterbury  
 Hardenbergh, D. B., Harvard '34, Bridgeport  
 Harper, P., Yale '31, Blatimore, Md. (Fairfield County)  
 Harris, B. R., Yale '22, New Haven  
 Harris, J. S., Yale '32, New Haven  
 Harris, H. P., Jr., Duke '36, Fairfield  
 Harris, L. D., Tufts '34, Hartford  
 Harrison, E. R., Yale '26, New Haven  
 Harrison, F. M., Jefferson '22, Stamford  
 Harrison, J. F., Jefferson '03, Stamford  
 Harshbarger, I. L., Virginia '22, Bridgeport  
 Hart, B. I., Columbia '04, Bridgeport  
 Hart, C. J., Hahnemann '03, New Britain  
 Hart, J. C., Yale '30, New Haven  
 Hart, J. G., Long Island '41, Westport  
 Hartman, F. B., Harvard '34, New London  
 Harty, J. E., Georgetown '37, Waterbury  
 Harvey, C. C., Cornell '16, Middletown  
 Harvey, D. F., Yale '33, Hartford  
 Harvey, E. R., Baltimore '09, Seymour  
 Harvey, E. R., Jr., Yale '37, Seymour  
 Harvey, J. LeR., Louisville '14, Waterbury  
 Harvey, S. C., Yale '11, New Haven  
 Harvey, T. S., Yale '41, Philadelphia, Penn. (New Haven County)  
 Hastings, L. P., Vermont '23, Hartford  
 Hathaway, J. S., Harvard '28, New Haven  
 Havey, L. A., Vermont '10, Bridgeport  
 Havill, R. A., Rochester '39, Auburn, N. Y. (New Haven County)  
 Hawthorne, J., Tulane '20, Greenwich  
 Haylett, H. B., Vermont '07, East Hartford  
 Hazen, D. R., Harvard '33, Hartford  
 Hazen, R., Vermont '98, Thomaston

- Heafey, J. R., Syracuse '34, South Norwalk  
 Hebard, G. W., Cornell '36, New Canaan  
 Heinemann, M., Goettingen '25, New Haven  
 Hellijas, C. S., Rochester '41, Hartford  
 Hendel, I., Jefferson '17, New London  
 Henderson, A. C., Columbia '03, Stamford  
 Henderson, J., Columbia '31, Stamford  
 Hendricks, A. L., Yale '07, New Haven  
 Henkle, E. A., Cornell '09, New London  
 Henkle, R. T., Cornell '31, New London  
 Hennessey, J. G., Tufts '34, Bridgeport  
 Hennessy, J. J., Columbia '26, Hartford  
 Henze, C. W., Yale '00, New Haven  
 Hepburn, R. H., Harvard '39, Hartford  
 Hepburn, T. N., Johns Hopkins '05, Hartford  
 Herman, D. W., Columbia '24, Winsted  
 Herr, E. A., Vermont '09, Cheshire  
 Herrick, F. L., Vermont '31, New Haven  
 Herrmann, A. E., Harvard '23, Waterbury  
 Hersey, T. F., Tufts '37, New Haven  
 Hertzberg, R. F., Harvard '26, Stamford  
 Hervey, Z. P., Vienna '38, East Hartford  
 Hess, O. W., Buffalo '31, New Haven  
 Hetzel, J. L., Yale '26, Waterbury  
 Heublein, G. W., Yale '34, Hartford  
 Hewes, C. T., Vermont '31, Groton  
 Heyer, H. H., U. City N. Y. '87, New London  
 Heyman, J., Med. Coll. Va. '17, Hartford  
 Hiden, R. B., Virginia '23, New Canaan  
 Hieronymus, E. E., Louisville '33, Louisville, Ky. (New Haven County)  
 Higgins, H. E., U. City N. Y. '96, Norwich  
 Higgins, H. G., Cornell '33, Milford  
 Higgins, H. W., Tufts '32, Norwich  
 Higgins, J. J., Georgetown '28, New Haven  
 Higgins, W. L., U. City N. Y. '90, South Coventry  
 Hill, E. R., Jefferson '24, Mystic  
 Hill, E. S., McGill '23, Torrington  
 Hill, W. E., Bowdoin '21, Naugatuck  
 Hillman, M. M., Columbia '19, New Haven  
 Hills, L. H., Wom. Med. Pa. '96, Winter Haven, Fla. (Windham County)  
 Hinchey, R. J., Tufts '21, Waterbury  
 Hippolitus, P. D., Yale '12, Bridgeport  
 Hirata, I., Yale '12, New Haven  
 Hirschfeld, O. M., Tufts '31, Hartford  
 Hirshberg, M. S., Tufts '27, Hartford  
 Hitchins, C. S., Cornell '38, New Haven  
 Hodgkins, C. H., Hahnemann '36, New Haven  
 Hodgson, T. C., Toronto '94, Berlin  
 Hoff, E. C., Oxford '28, Richmond, Va. (New Haven County)  
 Hoffman, C. C., Buffalo '16, Hartford  
 Hogan, W. L., Vermont '18, Hartford  
 Holley, E., Albany '96, Brattleboro, Vt. (Middlesex County)  
 Hollinshead, J. B., Yale '37, West Hartford  
 Holt, K. R., Yale '26, Hartford  
 Holtz, R. S., Vermont '28, Hartford  
 Hooper, G. H., Boston '29, Bridgeport  
 Hopper, E. B., Yale '29, Stamford  
 Hopper, J. M., Chicago '40, Hartford  
 Horn, B., N. Y. U. '29, Bridgeport  
 Horn, M. I., N. Y. Homeo. '15, Bridgeport  
 Horning, B. G., Harvard '28, Battle Creek, Mich. (Hartford County)  
 Horowitz, I., Vienna '37, Hartford  
 Horsefield, T. E., Vermont '29, Moodus  
 Hough, P. T., McGill '32, Hartford  
 Houle, R. T., Georgetown '32, East Hartford  
 Houze, H. G., Queens '24, Westport  
 Hovenanian, M. S., Boston '40, New Haven  
 Howard, A. J., Yale '20, New Haven  
 Howard, H. A., Tufts '29, Wethersfield  
 Howard, J. H., Georgetown '18, Bridgeport  
 Howard, L. A., Louisiana '39, Danbury  
 Howard, M. E., Johns Hopkins '31, New Haven  
 Howard, W. O., N. Y. U. '32, Tuskegee, Ala. (New Haven County)  
 Howe, G. E., Harvard '18, Hartford  
 Howlett, K. S., Vanderbilt '31, Shelton  
 Hubert, G. R., Yale '35, Torrington  
 Hudson, F. A., Pennsylvania '37, Bristol  
 Hughson, D. T., Yale '27, New York City (New Haven County)  
 Hughson, F. G., Marquette '34, Madison  
 Humpage, N. W., Tufts '36, Torrington (Hartford County)  
 Hunkemeier, E., N. Y. U. '33, South Norwalk  
 Huntington, F. S., Harvard '24, Darien  
 Hurlburt, E. G., Vermont '35, Bridgeport  
 Hurwitz, A., Johns Hopkins '33, Newington  
 Hurwitz, G. H., Maryland '33, Hartford  
 Huss, J. H., Cornell '42, Meriden  
 Hutchison, J. E., Johns Hopkins '14, Hartford  
 Hyde, C. E., Yale '10, Bridgeport  
 Hymovich, L., Jefferson '29, Stamford  
 Hynes, F. H., Tufts '13, New Haven  
 Iannotti, J. P., Naples '38, Plainville  
 Ignace, S. J., Georgetown '30, Derby  
 Inkster, J. H., Cornell '30, Ridgefield  
 Ireland, R. M., Vermont '31, New Milford (Fairfield County)  
 Irving, J. G., Toronto '32, Hartford  
 Irwin, H. H., Tufts '34, New London  
 Isenman, R., Tufts '30, Westport  
 Jack, J. L., Yale '23, New Haven  
 Jackson, A. F., Howard '22, Hartford  
 Jackson, A. H., Yale '24, Washington  
 Jackson, A. J., Columbia '15, Waterbury  
 Jackson, E. B., Johns Hopkins '21, New Haven  
 Jacobson, C. E., Jr., Cornell '35, Hartford  
 Jaffe, S. A., N. Y. U. '38, New Haven  
 Jaiven, S. J., N. Y. U. '40, Stamford  
 James, A. G. B., McGill '27, Bridgeport  
 James, G. R., Yale '10, Hamden  
 James, L. P., Yale '27, Hartford  
 James, M. L., Women's Med. Coll. Pa. '07, Waterbury  
 January, D. A., Yale '34, Hartford  
 January, M. H., Yale '35, Hartford  
 Jarvis, H. G., Johns Hopkins '10, Hartford  
 Jenkins, R. H., Med. Coll. Va. '16, New Haven  
 Jennes, M. L., Tufts '38, Waterbury  
 Jennes, S. W., Tufts '34, Waterbury  
 Jenovese, J. F., Pennsylvania '30, Hartford  
 Johnson, A. A., Columbia '17, Waterbury  
 Johnson, C. E., Harvard '26, New Haven  
 Johnson, H. A., Vermont '25, Watertown (New Haven County)  
 Johnson, P., Tufts '32, Hartford  
 Johnson, W. H. N., Jr., Howard '39, Norwalk  
 Johnston, E. H., Maryland '00, Waterbury  
 Johnstone, K. T., Cincinnati, '34, Bridgeport  
 Jones, E. K., Columbia '34, Bridgeport  
 Jones, F. S., Yale '28, Hartford  
 Jordan, R. H., Virginia '33, New Haven  
 Josephs, W. W., Georgetown '30, New Haven  
 Joyce, W. M., Jefferson '17, Middletown



Kahn, E., Munich '11, New Haven  
Kalett, J., Jefferson '28, New Britain  
Kalin, J. I., Harvard '24, Hartford  
Kalman, E., Royal Elizabeth U., Hungary '23, Bridgeport  
Kane, J. H., Md. Coll. Med. '04, Thomaston  
Kaplan, L., Baylor '36, Bridgeport  
Kaprielian, H. K., Virginia '08, Old Greenwich  
Kardys, J. A., George Washington '30, Hartford  
Karlin, F. L., St. Andrews '34, Waterbury  
Karotkin, R. H., N. Y. U. '32, Hartford  
Karpe, R., Prague '24, Hartford  
Kartin, B. L., Columbia '39, New Haven  
Kaschmann, J., Munich '22, Hartford  
Kaschub, R. W., Tufts '35, Groton  
Katz, D., Vermont '25, Hartford  
Katz, H., Harvard '21, Hartford  
Katz, H. W., Tufts '40, New Haven  
Katz, I., N. Y. Med. Coll. '37, Meriden  
Katzenstein, R. E., Berne '38, Meriden (Middlesex County)  
Katzman, S. S., Jefferson '21, Hartford  
Kaufman, C., Jefferson '19, New London  
Kaufman, W., Michigan '38, Bridgeport  
Keating, G. A., Long Island '38, Milford  
Keating, J. J., N. Y. U. '34, New Milford (Fairfield County)  
Keddy, R. A., McGill '24, Stamford  
Keefe, G. G., Maryland '22, Hartford  
Keefe, R. S., Boston '25, Hartford  
Keefe, W. J., Maryland '31, Hartford  
Keegan, D. F., Maryland '21, Bridgeport  
Keeney, R. R., Jr., Tufts '34, Manchester  
Keith, A. R., Harvard '03, Hartford  
Kelemen, E., Budapest '25, Greenwich  
Kelley, N. R., Harvard '37, Rocky Hill  
Kelley, W. O., Johns Hopkins '37, Norwich  
Kellogg, H. K. W., Columbia '03, Norwalk  
Kelly, C. C., Johns Hopkins '14, Hartford  
Kelly, J. C., Queen's '28, Old Greenwich  
Kelly, L. C., Cornell '29, Waterbury  
Kendall, R. E., Johns Hopkins '21, Hartford  
Kennedy, C. S., Georgetown '30, Naugatuck  
Kennedy, R. E., Yale '36, Pinebluff, N. C. (Fairfield County)  
Kennedy, W. C., Georgetown '10, New Haven (Litchfield County)  
Kenney, W. E., Yale '41, Hartford  
Kertesz, J., Vienna '24, New Haven  
Kessler, F., Vienna '37, West Haven  
Kettle, R. H., Queen's '28, Norwich  
Keys, R. C., Kansas '27, South Norwalk  
Kezel, A. P. C., Georgetown '35, Stamford  
Kilbourn, A., Yale '23, Hartford  
Kilbourn, J. B., P. & S., Balt. '11, Hartford  
Kilgus, J. F., Maryland '31, Litchfield  
Kinder, F. S., Cornell '38, Bridgeport  
Kingman, J. H., Columbia '85, New Haven (Middlesex County)  
Kingsbury, I. W., Columbia '03, Hartford  
Kinney, K. K., Iowa '21, Willimantic  
Kinsella, M. A., Tufts '12, Hollywood, Fla. (Hartford County)  
Kirby, S. B., Yale '28, New Haven  
Kirsch, N., Long Island '40, Hartford  
Kirschbaum, E. H., Yale '12, Waterbury  
Klatskin, G., Cornell '33, New Haven  
Klebanoff, H. E., Yale '25, New Haven  
Klein, A. A., Louisville '29, Hartford  
Klein, J., Long Island '34, Hartford  
Klein, R. H., Women's Med. Pa. '40, West Hartford  
Kleiner, S. B., Yale '15, New Haven  
Kleinman, H. L., Buffalo '41, Bridgeport  
Klumpp, T. G., Harvard '28, New York City (New Haven County)  
Knapp, C. S., Columbia '19, Greenwich  
Knapp, C. W., Columbia '12, Greenwich  
Knapp, R. P., Columbia '11, Manchester  
Knauth, M. S., Columbia '23, Wilton  
Kneale, H. B., Johns Hopkins '20, Bridgeport  
Knepp, J. W., Richmond '05, Hartford (Fairfield County)  
Knight, H. C., Tulane '33, Middletown  
Knowlton, D. J., Harvard '12, Winthrop, Me. (Fairfield County)  
Knowlton, M., Med. Coll. Ind. '05, Hartford  
Koffler, A., Jefferson '34, Stamford  
Koleshko, L. J., Maryland '42, Waterbury  
Konopka, F. J., Georgetown '31, Wallingford  
Kornblut, A., N. Y. U. '20, Bridgeport  
Koster, L. W., N. Y. U. '37, West Haven  
Kott, J. H., N. Y. U. '33, Torrington  
Koufman, W. B., Tufts '35, New Haven  
Kowalewski, V. A., Yale '02, West Haven  
Krall, I. H., Long Island '37, Hartford  
Kraszewski, H. W., Tufts '38, New Britain  
Krinsky, C. M., Tufts '33, New London  
Krochmal, H., Vienna '37, Meriden  
Krosnick, G., Jefferson '38, Boston, Mass. (New Haven County)  
Krosnick, M. Y., Yale '30, New Haven  
Kucewicz, W. J., St. Louis '36, Thompsonville  
Kunkel, F. E., Yale '26, Hartford  
Kunkel, P., St. Louis '34, Newington  
Kushlan, S. D., Yale '35, New Haven  
Kyle, G. B., Long Island '38, Sandy Hook  
Laakso, A. O., Cornell '37, Danielson  
La Bella, L. O., Columbia '25, Middletown  
Labensky, A., Yale '21, New London  
LaBrecque, F. C., Tufts '35, Waterbury  
Labuz, E. F., Tufts '37, Bristol  
Lacava, J. J., Georgetown '34, New Britain  
Lambert, H. B., Jefferson '09, Bridgeport  
LaMoure, C. TenE., Albany '94, Windham Center (Tolland County)  
Lamoureux, E. E., Tufts '35, Hartford  
Lampson, E. R., Columbia '06, Hartford  
Lampson, R. S., Harvard '34, Hartford  
Landecker, N., Friedrich Wilhelm '26, Bridgeport  
Landry, A. B., Jefferson '09, Hartford  
Landry, B. B., Harvard '20, Hartford  
Lang, W. P., Hahnemann '01, North Haven  
Langner, H. P., Yale '22, Milford  
Lankin, J. J., Harvard '37, Hartford  
Lapenta, R. G., George Washington '37, Hartford  
LaPlume, A. A., Montreal '24, Bristol  
Larimore, L. D., Wom. Med. Pa. '15, Greenwich  
Larkin, C. L., Yale '15, Waterbury  
Larrabee, J. W., Harvard '26, Hartford  
Larson, A. L., Albany '35, Hartford  
Laszlo, A., Kiel '23, Bridgeport  
LaTaif, C. G., Hahnemann '36, New Milford  
Latimer, M. L., Vanderbilt '32, New Haven  
Laube, P. J., Iowa '36, New Haven  
Lavietes, P. H., Yale '30, New Haven  
Lawton, R. J., Md. Coll. Med. '08, Terryville  
Leak, R. L., Albany '98, West Hartford  
Lear, M., Yale '11, New Haven  
Leary, D. C., Yale '36, Washington, D. C. (Windham County)

- Lechause, R. M., Med. Coll. of Va. '35, Manchester  
 Leddy, P. A., Harvard '24, South Portland, Me. (New  
 Haven County)  
 Lee, F. N., Kansas '23, Milford  
 Lee, J. R., Queen's '24, Devon  
 Lehndorff, P. G., Vienna '37, Boston, Mass. (Windham  
 County)  
 Lekston, R. F., Med. Chi., Phila. '15, New Britain  
 Lena, H. F., Johns Hopkins '16, New London  
 Lencz, E. D., Vienna '36, Ansonia  
 Lenehan, J. R., Jefferson '37, Hartford  
 Lengyel, P., Budapest '31, Bridgeport  
 Lenkowski, W. J., N. Y. U. '37, Waterbury  
 Lennox, M. A., Yale '39, New Haven  
 Lenoci, R. J., Hahnemann '40, Bridgeport  
 Leonard, G. A., Md. Coll. Med. '05, Waterbury  
 Leonard, J. C., Yale '32, Hartford  
 Leonard, M., Yale '31, New Haven  
 Leonard, R. J., Georgetown '38, New Haven (Tolland  
 County)  
 Leong, E. F., Rush '26, Stamford  
 Lepreau, F. J., Jr., Harvard '38, New Bedford, Mass. (New  
 Haven County)  
 Lesko, J. M., Duke '38, Bridgeport  
 Levenson, A., Tufts '22, Bridgeport  
 Leverty, C. J., Univ. & Bellevue '01, Bridgeport  
 Levin, A. E., Tufts '30, Hartford  
 Levin, C. A., Johns Hopkins '20, Hartford  
 Levin, H. A., Univ. & Bellevue '18, New Haven  
 Levin, R. R., Harvard '36, Hartford  
 Levine, H., Harvard '41, New Britain  
 Levine, L. W., Maryland '37, Ellington  
 Levine, S. S., P. & S., Balt. '12, Hartford  
 Levinsky, M., Maryland '28, Bridgeport  
 Levy, A., Tufts '31, Winsted  
 Levy, D. F., Yale '19, New Haven  
 Levy, M. N., Tufts '23, Bridgeport  
 Levy, N., Yale '27, Branford  
 Levy, S. H., Tufts '35, Stratford  
 Levy, W., Yale '11, Suffield  
 Lewicki, E. S., Georgetown '35, Waterbury  
 Lewis, D. M., Johns Hopkins '01, New Haven  
 Lewis, R. M., Pennsylvania '10, New Haven  
 Lewis, S. D., George Washington '31, Hartford  
 L'Heureux, J. A., Boston '34, Meriden  
 Lieberman, D. L., N. Y. U. '26, Middletown  
 Lieberthal, M. M., N. Y. U. '35, Bridgeport  
 Liebow, A. A., Yale '35, New Haven  
 Linde, J. I., Yale '08, New Haven  
 Lindsay, M. K., Columbia '10, Washington, D. C. (New  
 Haven County)  
 Lindsay, M. S., Tufts '11, Middletown  
 Linskog, G. E., Harvard '28, New Haven  
 Lipkoff, C. J., N. Y. U. '36, Milford  
 Lipton, H., St. Louis '32, Danbury  
 Lirot, S. L. R., McGill '32, Meriden  
 Lischner, M. D., Yale '30, Hartford  
 Litter, L., Basel '36, Hartford  
 Little, H. C., Yale '10, New Haven  
 Little, M. F., Yale '28, Hartford  
 Little, M. H., Harvard '35, Willimantic  
 Little, O. A. G., Boston '35, Willimantic  
 Littwin, R. J., Long Island '36, Bristol  
 Lobb, R. A., Hahnemann '37, Deep River  
 Locke, H. L. F., Tufts '12, Hartford  
 Lockhart, R. H., Yale '28, Bridgeport  
 Lockwood, H. DeF., Yale '01, Meriden  
 Lockwood, J., Johns Hopkins '30, Greenwich  
 Lockwood, J. S., Harvard '31, New York City (New Haven  
 County)  
 Loffredo, L., Pennsylvania '22, Middletown  
 Logan, W. J., Yale '25, New Haven  
 Lohrmann, W., Rochester '43, Meriden  
 Loiacono, A. J., Harvard '27, New London  
 Lolli, G., Rome '28, New Haven  
 Lombardi, P. F., Tufts '21, Waterbury  
 Longo, A. D., Georgetown '38, Portland  
 Lopatin, C., Louisville '41, Bridgeport  
 LoRusso, D. L., Marquette '34, Torrington  
 Louderbough, H., Vermont '38, Watertown  
 Loveland, E. K., Yale '07, Watertown  
 LoVetere, A. A., George Washington '35, New Britain  
 Lowell, W. H., Jr., Harvard '37, Hartford  
 Lowman, R. M., Maryland '36, New Haven  
 Lubchansky, J. H., N. Y. U. '33, Uncasville  
 Lublin, R. D., Johns Hopkins '29, East Hartford  
 Luby, T. J., McGill '14, Hartford  
 Luckner, W. G., Jefferson '38, Stafford Springs  
 Ludlow, G. C., Harvard '19, New Canaan  
 Lukoski, W. A., Georgetown '32, Waterford  
 Lundberg, G. A. F., Jefferson, '19, South Manchester  
 Lundborg, F. L., Yale '30, West Hartford  
 Lutz, W. G., Munich '36, New York City (New Haven  
 County)  
 Lydon, L. G. M., Yale '40, New Haven  
 Lyddy, J. R., N. Y. U. '44, Bridgeport  
 Lyman, D. R., Virginia '09, Wallingford  
 Lynch, E. J., Pennsylvania '09, Shelton  
 Lynch, H., N. Y. U. '24, Bridgeport  
 Lynch, J. C., U. City N. Y. '86, Bridgeport  
 Lynch, R. J., Bellevue '97, Bridgeport  
 Lynch, V. A., Jefferson '38, Bridgeport  
 Lyon, G. A., Cornell '41, Bridgeport  
 MacCready, P. B., Johns Hopkins '21, New Haven  
 MacCready, W. H., Harvard '27, Windsor  
 MacDougall, A. D., Cornell '43, New London  
 Mackay, W. D., Indiana '28, Sharon  
 MacLean, E. M., McGill '30, Farmington  
 MacLeod, E. A., Wom. Med. Pa. '25, Niantic  
 Madden, L. I., Harvard '10, Hartford  
 Magnano, J., Yale '27, Middletown  
 Maher, J. R., Boston '27, Stratford  
 Mahoney, D. F. C., Georgetown '24, Redlands, Calif. (Hart-  
 ford County)  
 Mahoney, J. J., McGill '33, Norwich  
 Maislen, S., Vermont '14, Hartford  
 Malloy, E. F., Cornell '28, Stamford  
 Malone, R. F., Tufts '43, Milford  
 Mancoll, M. M., Jefferson '28, Hartford  
 Mandl, G., Vienna '32, Bethel  
 Manganiello, L. O. J., Maryland '42, Waterbury  
 Manwaring, I. J., Pennsylvania '95, Norwich  
 Marglis, B., Bowdoin '20, Bridgeport  
 Margolick, M., McGill '35, Putnam  
 Margolius, N., Cornell '33, Waterbury  
 Marinaro, N. A., St. Louis '30, Hartford  
 Marinoff, P. A., Rome '41, Milford  
 Markle, R. D., Syracuse '37, Waterbury (Litchfield County)  
 Markoff, A., Long Island '32, New Haven  
 Markoff, K. K., Vermont '19, Norwich  
 Markwald, H. W., Berlin '37, Torrington  
 Marranzini, S., N. Y. U. '28, Hartford  
 Marsh, A. D., Yale '08, Hampton  
 Marshak, I. J., Tufts '26, New Haven  
 Marshall, C. L., Howard '24, New Haven



- Martin, J. G., Yale '33, West Hartford  
 Martin, J. S., Yale '05, Watertown  
 Martin, R. A., Vermont '37, Bridgeport  
 Martin, S. J., Wisconsin '35, Hartford  
 Marvin, H. M., Harvard '18, New Haven  
 Maslak, R., Louisville '34, Warehouse Point  
 Massa, A. F., Yale '18, New Haven  
 Massaro, J., Yale '45, Manchester  
 Massey, D. M., Hahnemann '36, Bridgeport  
 Mastrangelo, A., Jr., Boston '39, Stamford  
 Mastroianni, L., Padua '17, New Haven  
 Mathews, F. P., Harvard '30, New Haven  
 Matteis, J. T., Yale '26, New Britain  
 Maurer, L. L., Yale '16, New Haven  
 Maurer, W. S., Yale '38, Willimantic  
 Maxwell, J. A., Med. Coll. Va. '17, Bridgeport  
 Maynard, H. H., Yale '16, New Haven  
 Mayo, E. R., Tufts '38, Waterbury  
 McAlenney, P. F., Yale '29, New Haven  
 McCabe, E. J., Yale '26, New York City (New Haven County)  
 McClellan, W. E., Toronto '04, Hartford  
 McCombs, A. P., Cornell '29, Wilton  
 McCormack, C. J., Yale '29, Hartford  
 McCrann, D. J., Tufts '34, Hartford  
 McCreery, J. A., Columbia '10, Greenwich  
 McCue, M. P., Harvard '34, East Hartford  
 McDermott, J. F., Cornell '23, Hartford  
 McDonnell, R. E., Yale '20, New Haven  
 McFarland, F. W., Vermont '28, Stamford  
 McGaughey, J. D., Jefferson '10, Wallingford  
 McGaughey, J. D., III, Jefferson '44, Wallingford  
 McGourty, A. F., N. Y. Homeo. '18, Stamford  
 McGourty, D. P., Jefferson '27, Stamford  
 McGovern, E. F., Univ. & Bellevue '01, Bridgeport  
 McGrath, J. F., McGill '23, Hartford  
 McGrath, J. H., Yale '08, Waterbury  
 McGuire, F. J., Boston '37, Guilford  
 McGuire, W. C., Yale '09, New Haven  
 McKeon, J. J., Hahnemann '39, Hamden  
 McLarney, T. J., P. & S., Balt. '97, Hartford (New Haven County)  
 McLaughlin, J. H., P. & S., Balt. '09, Jewett City  
 McLean, J. J., Tufts '20, Hartford  
 McLean, T. S., Jr., Vermont '34, Bridgeport  
 McLellan, P. G., Harvard '25, Hartford  
 McLeod, C. E., Vermont '34, Middletown  
 McMahon, F. C., Fordham '19, Stamford  
 McMahon, G. W., Tufts '37, New Britain  
 McMahon, J. D., Creighton '37, South Norwalk  
 McMahon, W. H., Jr., Fordham '20, South Norwalk  
 McNulty, T. F., Georgetown '32, Hartford  
 McPartland, C. E., Johns Hopkins '23, West Hartford  
 McQueen, A. S., Yale '01, Branford  
 McQueeney, A. M., Yale '05, Bridgeport  
 Meacham, C. T., Pennsylvania '30, Stamford  
 Meeker, D. O., Rochester '29, Riverside  
 Mekrut, J. A., St. Louis '31, Meriden  
 Mellion, J., Yale '23, New Britain  
 Mendelsohn, W., Johns Hopkins '33, New Haven  
 Mendillo, A. J., Yale '07, New Haven  
 Mendillo, J. C. F., Yale '30, New Haven  
 Menousek, J. A., Vermont '32, Plainville  
 Meo, R. C., George Washington '34, Waterbury  
 Merrill, W. T., Dartmouth '90, East Milton, Mass. (New Haven County)  
 Merriman, H., Columbia '36, Waterbury  
 Merriman, M. H., Columbia '06, Waterbury  
 Meschter, E. F., Med. Chi. Phila. '98, Stamford  
 Meshken, J., Rush '37, Bridgeport  
 Messina, M. C., Tennessee '27, Bay Pines, Fla. (Hartford County)  
 Metcalf, E. H., Jefferson '14, Rockville  
 Meyer, F. M., Indiana '28, Bridgeport  
 Meyers, R. A., Michigan '31, Watertown  
 Mezey, C. M., Royal U. Budapest '18, Great Fall, Montana (New London County)  
 Michalowski, V. S., Boston '29, New Britain  
 Middlebrook, L. F., Jr., Johns Hopkins '30, Hartford  
 Mignone, J., Yale '33, New Haven  
 Milano, N. A., Georgetown '27, West Haven  
 Miles, H. S., Columbia '91, Bridgeport  
 Milici, J. J., Hahnemann '40, New Haven  
 Millen, S. R., George Washington '38 Rocky Hill (New Haven County)  
 Miller, G. R., Tufts '39, Manchester  
 Miller, H. B., Rush '33, Hartford  
 Miller, H. K., Columbia '32, Stamford  
 Miller, J., Cornell '15, Greenwich  
 Miller, J. R., Johns Hopkins '11, Hartford  
 Miller, S. M., Tulane '41, West Hartford  
 Mills, B. L., Vermont '25, Meriden  
 Mills, C. W., Cornell '38, South Norwalk  
 Minor, L. W., Yale '32, Middletown  
 Mirabile, C. S., McGill '30, Hartford  
 Mirabile, T. J., Georgetown '37, East Hartford  
 Missett, J. S., Columbia '40, West Hartford  
 Misuk, J. F., Georgetown '32, Meriden  
 Mitchell, G. V., McGill '38, Torrington  
 Mlynarski, J. A., Georgetown '39, New Britain  
 Mogil, M., Buffalo '39, New Haven  
 Moher, J. J., Yale '37, Hartford  
 Moise, T. S., Johns Hopkins '17, Hartford  
 Molnar, G. J., Georgetown '43, Bridgeport  
 Monacella, J. M., Columbia '35, Windsor  
 Monahan, D. T., Yale '33, Bridgeport  
 Mongillo, F., Med. Coll. Va. '28, New Haven  
 Montano, C. C., Tufts '35, Hartford  
 Montano, R. A., Tufts '33, Hartford  
 Mooney, S., Tufts '27, Bridgeport  
 Moorad, P. J., Rochester '31, New Britain  
 Moore, B. E., Harvard '37, New Haven  
 Moore, C. D., Queen's '28, Stamford  
 Moore, D. B., Tufts '35, New Haven  
 Moore, D. C. Y., N. Y. Homeo. '95, Manchester  
 Moore, G. E., Yale '34, Darien  
 Moore, H. F., Missouri '98, Bethel  
 Moore, M. R., Queen's '29, Norwich  
 Moore, W. J., Columbia '21, Cheshire  
 Morgan, K. R., Yale '42, New Haven  
 Morgan, W. O., Georgetown '30, Westport  
 Moriarty, M. E., Yale '26, South Manchester  
 Morrill, H. F., Harvard '25, Waterbury  
 Morris, F. R., Maryland '41, Stratford  
 Morris, J. S., Texas '27, Greenwich (New London County)  
 Morriss, W. H., Johns Hopkins '12, Wallingford  
 Morrisett, L. E., Med. Coll. Va. '36, Greenwich  
 Morrissey, M. J., P. & S., Balt. '97, Hartford  
 Morse, A. H., Johns Hopkins '06, Hamden  
 Morse, L. R., Queen's '26, Hartford  
 Morse, W. J., Vermont '31, New London  
 Moser, O. A., Yale '02, Rocky Hill  
 Moss, H. G., N. Y. U. '28, New Haven  
 Mott, F. E., Buffalo '41, Brooklyn, N. Y. (New Haven County)  
 Mouradian, M. G., Wom. Med. Coll. Pa. '13, New Britain  
 Moxness, B. A., Georgetown '25, U. S. Army (Hartford County)

- Moxon, G. F., Marquette '30, Mansfield Depot (Windham County)
- Moylan, T. P., Buffalo '22, Hartford
- Moyle, H. B., Toronto '10, Hartford
- Mozzer, A. J., Hahnemann '38, Hartford
- Mucci, L. A., Rochester '34, New Britain
- Mullen, J. J., Tufts '29, Waterbury
- Mulligan, M., Boston '38, Waterbury
- Mullins, S. F., Univ. & Bellevue '06, Danbury
- Mulville, M. F., Tufts '37, Hartford
- Murcko, W. J., Marquette '37, Torrington
- Murdock, T. P., Maryland '10, Meriden
- Murphy, C. A., Long Island '33, Stamford
- Murphy, J., Pennsylvania '95, Middletown
- Murphy, J. J., Georgetown '35, Danbury
- Murphy, O. L., Vermont '21, Simsbury
- Murphy, T. B., Harvard '23, Wallingford
- Murphy, T. D., Columbia '30, Simsbury
- Murphy, T. F., Jefferson '33, West Hartford
- Murray, H. J., Jefferson '16, Stamford
- Murray, T. J., Maryland '10, New London
- Murray, T. O., Tufts '32, Danbury
- Murray, W. J., Jefferson '32, Bridgeport
- Musselman, L. K., Johns Hopkins '19, New Haven
- Mylon, E., Berlin '20, New Haven
- Nagle, W. T., Med. Chi. Phila. '14, Southington
- Nahum, L. H., Yale '16, New Haven
- Narowski, J. J., Tufts '43, Derby
- Naylor, J. H., Vermont '95, Hartford
- Neff, W. E., Jr., Columbia '33, Cheshire
- Neidlinger, W. J., Cornell '33, Hartford
- Nelson, R. B., Cornell '34, Ithaca, N. Y. (New Haven County)
- Nelson, W. N., George Washington '26, Cromwell
- Nemoitin, B. O., Long Island '34, Stamford
- Nemoitin, J., Columbia '05, Stamford
- Nesbit, R. R., Albany '29, New Haven
- Nespeco, J. V., Georgetown '32, Bridgeport
- Nespor, R. W., Boston '33, Westport
- Nestos, P. A., Rush '14, Bristol
- Nettleton, I. LaF., Long Island '08, Bridgeport
- Neumann, H. A., Long Island '09, Bridgeport
- Neumann, V. F., Michigan '29, Norwich
- Neuswanger, C. H., Harvard '23, Waterbury
- Nevulis, A. V., Vermont '38, Newington
- Newman, H. R., Toronto '35, New Haven
- Newman, J. T., Yale '19, New Haven
- Newman, R., Johns Hopkins '30, New Haven
- Newton, L., N. Y. Homeo. '31, Bridgeport
- Nichols, C. W., Vermont '20, Bridgeport
- Nichols, E., Yale '39, Hartford
- Nichols, R. W., Johns Hopkins '12, New Haven
- Nickum, J. S., Tufts '18, Bridgeport
- Nielsen, T. M., Copenhagen '38, New London
- Nodelman, J., Yale '29, New Haven
- Nolan, J. F., McGill '32, Bridgeport
- Northman, F. F., Breslau '34, Bridgeport
- Northrop, R. A., Jefferson '32, Norwalk
- Nyboer, J., Michigan '35, Hartford
- Oberg, F. T., Harvard '16, Bridgeport
- O'Brasky, G. H., Jefferson '20, New Haven
- O'Brasky, L., Jefferson '22, New Haven
- O'Brien, H. R., Michigan '19, Washington, D. C. (Hartford County)
- O'Brien, J. F., Yale '08, Waterford
- O'Brien, W. H. J., Yale '12, New Haven
- O'Connell, E. J., Tufts '34, Unionville
- O'Connell, J. D., Harvard '39, Hartford
- O'Connell, J. F., Vermont '21, Hartford
- O'Connell, J. G., Tufts '17, Bridgeport
- O'Connell, M. F., Yale '22, Hartford
- O'Connell, P. H., Loyola '29, Norwich
- O'Connell, W. M., Yale '17, West Haven
- O'Connor, D. S., Bowdoin '19, New Haven
- O'Donnell, T. J., Syracuse '08, Greenwich
- Oelschlegel, H. C., Jefferson '11, Torrington
- Oesau, H. T., Jefferson '26, Stratford
- O'Flaherty, E. P., Cornell '01, Hartford
- Ogden, F. N., Columbia '42, Norwalk
- Ogden, R. T., Harvard '24, Hartford
- Ogilvie, J. B., Yale '34, Stamford
- Olmsted, J. G. M., McGill '25, Hartford
- O'Loughlin, T. F., U. City N. Y. '96, Rockville
- Oltman, J. E., Minnesota '34, Newtown
- O'Meara, F. P., N. Y. Med. Coll. '36, Stamford
- Onderdonk, H. J., Univ. & Bellevue '97, East Hartford
- O'Neil, M. L., Yale '29, Jewett City
- O'Neil, V. D., McGill '41, Newington
- O'Neill, C. W., Yale '26, Hartford
- O'Neill, J. J., Tufts '32, Bridgeport
- Oppenheimer, K., Heidelberg '20, Norwich
- Oppel, L., Munich '33, Torrington (New London County)
- Orbach, E. J., Friedrich Wilhelm Univ., Berlin '24, New Britain
- Orlowski, A. W., Tufts '36, Torrington
- Oros, L. M., Budapest '37, Bridgeport
- Osborn, S. H., Tufts '14, Hartford
- Osgood, C., Columbia '03, Norwich
- Osmond, R. H., Yale '23, Hartford
- Oster, K. A., Cologne '34, Bridgeport
- Otis, F. N., Tufts '18, Meriden
- Otis, I. S., George Washington '17, Meriden
- Ottenheimer, E. J., Virginia '22, Willimantic
- Oughterson, A. W., Harvard '29, New Haven
- Owen, P. S., Yale '37, Chester
- Owens, A. P., McGill '37, Bridgeport
- Oxnard, E. W., Harvard '36, Cheshire
- Padula, R. D., Cincinnati '30, Norwalk
- Padula, V. D., Rome '35, Hartford
- Pagliaro, J. J., Georgetown '37, Shelton
- Paladino, J. S., Boston '26, Hartford
- Paley, I. M., Long Island '36, Stamford
- Palmieri, M. L., Yale '32, Middletown
- Palmieri, M. W., Naples '33, New Haven
- Panettieri, A. J., Vermont '37, Bridgeport
- Paolillo, C. G., Yale '35, New Britain
- Papa, J. S., Tufts '28, Bristol
- Parente, L., Emory '31, Hamden
- Paris, M., N. Y. U. '30, South Norwalk
- Park, P. A., Iowa Homeo. '10, Bristol
- Parker, J. W., Yale '06, Hartford
- Parker, R. L., Western Ontario '41, Bridgeport
- Parlato, H. A., N. Y. U. '36, New Britain
- Parlato, M. A., Yale '08, Derby
- Parmelee, B. M., Vermont '19, Bridgeport
- Parmelee, E. K., Long Island '89, Ansonia
- Parrella, G. S., Yale '41, Newington (New Haven County)
- Parrella, L. A., Tufts '34, North Haven
- Parshley, P. F., Pennsylvania '27, West Hartford
- Partridge, W. P., Harvard '20, Hartford
- Pascal, T. J., Rush '31, Bridgeport
- Pasetto, E., Vermont '36, Waterbury
- Pasquariello, D. W., Naples '36, Bridgeport
- Pasternak, M., Toronto '36, New Haven
- Patterson, F. A., Harvard '27, Norwalk



Paul, F., Munich '24, Norwalk  
 Paul, J. R., Johns Hopkins '19, New Haven  
 Paul, V. A., Hahnemann, Chicago '13, Stamford  
 Peacock, A. U., Rush, '33, Hartford  
 Pearce, M. G., Texas '22, New Canaan  
 Pease, M. C., Columbia '06, Ridgefield  
 Peck, B. C., Long Island '31, New Britain  
 Peck, R. E., Yale '93, Concord, New Hampshire (New Haven County)  
 Peckham C. H., Johns Hopkins '23, Manchester  
 Pellens, M., Cornell '30, Bridgeport  
 Pelliccia, O., Jr., Johns Hopkins '39, New Haven  
 Pelz, K., Vienna '32, Wallingford  
 Pendleton, C. E., Yale '03, Colchester  
 Pendleton, E. R., P. & S., Boston '04, Westfield, Mass. (Hartford County)  
 Penner, S. L., Columbia '34, Stratford  
 Pennington, H. F., Harvard '27, Meriden  
 Pepe, A. J., Maryland '35, Norwich  
 Perakos, G. P., Georgetown '32, New Britain  
 Perham, W. S., Michigan '32, New Haven  
 Perkins, C. W., Hahnemann '01, Norwalk  
 Perkins, J. A., McGill '41, Montreal, Canada (Hartford County)  
 Perreault, J. N., Tufts '07, Danielson  
 Perrins, H. B., Yale '18, New Haven  
 Perry, M. J., Wom. Med. Homeo. N. Y. '03, Norwalk  
 Peters, J. P., Columbia '13, New Haven  
 Peterson, C. K., Tufts '05, Lakeville  
 Petrelli, J., Yale '25, New Haven  
 Petrillo, C., Yale '38, New Haven  
 Pharris, C., Tennessee '29, Glastonbury  
 Phelps, M. O., McGill '29, Hartford  
 Phelps, P. S., McGill '30, Hartford  
 Phillipson, S., N. Y. Homeo. '18, New Haven  
 Phillips, F. L., Yale '06, New Haven  
 Phillips, H. S., Toronto '22, Westport  
 Phillips, K. T., Tufts '19, Putnam  
 Phillips, P. L., Cornell '30, Norfolk, Va. (Hartford County)  
 Piasecki, J. L., Maryland '12, Norwalk  
 Piasta, P. F., Boston '24, Middletown  
 Piazza, G. J., Boston '32, New Haven  
 Piccolo, P. A., Maryland '37, New Haven  
 Pierce, H. F., Johns Hopkins '35, West Hartford  
 Pierson, E. M., Yale '24, Cromwell  
 Pierson, L. A., Tufts '27, Meriden  
 Pike, E. R., Michigan '08, East Woodstock  
 Pike, M. M., Harvard '25, Hartford  
 Pilecki, P. J., Loyola '43, Middletown  
 Pileggi, P., Maryland '28, Bridgeport  
 Pinn, A. S., Laval '29, New Haven  
 Pitegoff, C. H., St. Louis '40, New Haven  
 Pitegoff, G. I., St. Louis '37, Hartford  
 Pitcock, M. P., Tufts '30, Bridgeport  
 Plachta, A., Warsaw '30, New York City (Hartford County)  
 Platt, J. W., Columbia '40, Mystic  
 Platt, I. S., Southern California '12, Waterbury  
 Platt, W. L., Columbia '81, Newtown (Litchfield County)  
 Plukas, J. M., Georgetown '32, Bridgeport  
 Poczabut, J. S., Vermont '41, Stamford  
 Pola, W. E., Louisville '32, New Britain  
 Polito, F. L., Yale '21, Torrington  
 Pollard, R. L., Tufts '36, Waterbury  
 Pomeroy, N. A., Columbia '96, Waterbury  
 Poole, A. K., Johns Hopkins '23, New Haven  
 Popkin, M. S., George Washington '35, Bridgeport  
 Post, E. A., Georgetown '33, Waterbury  
 Poverman, D., Vermont '32, New Haven

Powell, W., Queen's '24, New Haven  
 Powers, G. F., Johns Hopkins '13, New Haven  
 Pratt, A. M., Univ. & Bellevue '92, Deep River  
 Pratt, A. P., Harvard '22, Windsor  
 Pratt, E., Columbia '87, Essex (Litchfield County)  
 Pratt, G. K., Detroit '15, Bridgeport  
 Pratt, N. T., Yale '04, Old Saybrook (Fairfield County)  
 Preston, T. R., Yale '25, Hartford  
 Priddy, F. E., Northwestern '28, Hartford  
 Prignano, J. V., Georgetown '40, Manchester  
 Prior, J. D., Toronto '28, Waterbury  
 Prosser, F. D., Cornell '28, Putnam  
 Prout, E. B., Syracuse '14, Portland  
 Pullen, R. W., Yale '21, New Britain  
 Purinton, C. O., Yale '00, New Hartford (Hartford County)  
 Purney, J., Jr., McGill '39, West Hartford  
 Pyle, E., Columbia '15, Waterbury

Quarrier, S. S., Columbia '32, Hartford  
 Quatrano, J. C., Vermont '31, Bridgeport  
 Quinlan, R. V., P. & S., Balt. '10, Meriden  
 Quinn, J. F., P. & S., Balt. '06, Bridgeport  
 Quinn, K. S., Temple '35, Bridgeport  
 Quinn, R. J., P. & S., Balt. '13, Waterbury  
 Quintiliani, A., Harvard '29, Norwich

Rabinovitch, A., Vermont '19, Norwich  
 Rademacher, E. S., Iowa '23, New Haven  
 Radin, M. J., Columbia '16, Hartford  
 Radom, M. M., Jefferson '25, Hartford  
 Raffa, J., Columbia '34, Glastonbury  
 Rafferty, B., Jefferson '28, Willimantic  
 Raffkind, A. B., Paris '37, Middletown  
 Rand, R. F., Johns Hopkins '00, New Haven  
 Randall, W. S., Columbia '86, Shelton  
 Rankin, B. F., McGill '19, Hartford  
 Rapp, A. G., Cornell '29, New London  
 Rasmussen, H. N., Tufts '25, Uncasville  
 Rawls, E. C., Med. Coll. Va. '31, Stamford  
 Raymer, J. G., Harvard '25, Willimantic  
 Raynolds, R., Columbia '14, New Haven  
 Read, F. A., Yale '34, Old Greenwich  
 Reade, E. G., Jefferson '16, Watertown  
 Reardon, W. F., P. & S., Balt. '04, Hartford  
 Redlich, F. C., Vienna '35, New Haven  
 Reich, U. S., Virginia '09, Bridgeport  
 Reichenbach, A. E., Tufts '38, Waterbury  
 Reidy, D. D., Columbia '27, Hartford  
 Reilly, W. J., Tufts '35, Naugatuck  
 Reiter, B. R., Harvard '34, Bridgeport  
 Renahan, J. M., Tufts '28, Ansonia  
 Rentsch, S. B., Michigan '23, Derby  
 Resnik, E., McGill '30, New Britain  
 Resnik, H., Johns Hopkins '31, Bridgeport  
 Resnik, W. H., Johns Hopkins '21, Stamford  
 Resnisky, A. F., Georgetown '23, West Hartford  
 Reynolds, H. St. C., Yale '10, Hartford  
 Reynolds, H. S., Albany '14, Hartford  
 Reynolds, J. A., Tufts '36, Waterbury  
 Reynolds, R. G., Harvard '26, Hartford  
 Reynolds, W. M., Columbia '31, Greenwich  
 Ribner, H., Tufts '34, Bridgeport  
 Ricca, R. A., Pennsylvania '40, Glastonbury  
 Riccio, J. S., St. Louis '37, New Haven  
 Riccitelli, M. L., Yale '22, New Haven  
 Richards, W. R., Cornell '35, New Haven

- Richardson, R. A., Vermont '14, Bristol  
 Riendeau, F. M., Paris '27, Torrington  
 Riendeau, P. L., Paris '27, Torrington  
 Riesmann, J. P., Pennsylvania '38, Branford  
 Rilance, A. B., McGill '31, New Haven  
 Rindge, M. E., Duke '41, Madison  
 Rindge, M. P., P. & S., Cleveland '05, Madison  
 Rindge, N. P., Yale '35, Clinton  
 Riordan, M. D., Vermont '12, Willimantic  
 Robb, S. A., Cornell '40, Meriden  
 Robbins, B. B., U. City N. Y. '94, Bristol  
 Roberge, G. E., Yale '38, Stratford  
 Roberts, D. J., Vermont '16, Hartford  
 Roberts, E. R., Maine '13, Bridgeport  
 Roberts, F. W., Johns Hopkins '24, New Haven  
 Robey, N. C., Yale '17, Patton, California (Fairfield County)  
 Robinson, A. J., Toronto '23, Hartford  
 Robinson, W. J. T., Long Island '21, Broad Brook  
 Robison, R. C., Yale '36, Stamford  
 Roccapriore, B. A., Jefferson '31, Middletown  
 Rocco, M. P., Georgetown '41, Hartford  
 Roch, G. E., Tufts '34, Willimantic  
 Roche, A. F., Georgetown '17, Hartford  
 Roche, T. J., P. & S. Balt. '11, Bridgeport  
 Rockwell, A. E., Johns Hopkins '21, Bridgeport  
 Rogawski, A. S., Vienna '38, Beverly Hills, California (New Haven County)  
 Rogers, F. P., Syracuse '33, West Hartford  
 Rogers, O. F., Jr., Harvard '12, New Haven  
 Rogers, P. H., Yale '12, West Haven  
 Rogers, R. P., Harvard '25, Greenwich  
 Rogol, L., Long Island '33, Danbury  
 Rogol, O., Dalhousie '32, Seymour  
 Rogowski, B. A., Yale '24, New Haven  
 Rollins, H. B., Yale '22, Hartford  
 Romaniello, R. J., Columbia '27, Elmwood  
 Rooney, J. F., P. & S., Balt. '03, Hartford  
 Root, J. H., Harvard '18, Waterbury  
 Root, J. H., Jr., Syracuse '43, Waterbury  
 Root, M. T., Cornell '18, West Hartford  
 Root, S. A., Cornell '19, West Hartford  
 Rosahn, P. D., N. Y. U. '28, New Britain  
 Rose, S. A., N. Y. U. '23, Stamford  
 Rosen, T., Tufts '33, Manchester  
 Rosenbaum, G. J., Tufts '34, Hartford  
 Rosenbaum, J. D., Yale '37, New Haven  
 Rosenberg, H. A., Vienna '37, Bridgeport  
 Rosenberg, H. A., Yale '30, Waterbury  
 Rosenberg, S., American Univ. Beirut '39, Bridgeport  
 Rosenthal, B. B., N. Y. U. '30, Milford  
 Rosenthal, E., Munich '25, Hartford  
 Rosenthal, I., Long Island '10, South Norwalk  
 Rosenthal, R. L., Long Island '38, Branford  
 Rosner, F., Vienna '37, Bridgeport  
 Ross, A. M., Basel '35, Darien  
 Roth, F. E., N. Y. U. '25, Hartford  
 Roth, O., Vienna '37, New Haven  
 Rothblatt, R., Harvard '37, Willimantic  
 Rothschild, M. L., Paris '26, New Haven  
 Rourke, T. A., Columbia '37, Greenwich  
 Rowley, J. C., Harvard '06, West Hartford  
 Rowley, R. L., Yale '03, Hartford  
 Roy, J. L., Tufts '34, West Palm Beach, Florida (Windham County)  
 Rozen, A. A., Yale '37, New Haven  
 Rubin, A., Geneva '29, Hartford  
 Rubin, G. A., Edinburgh '32, New Haven  
 Ruby, M. H., Columbia '21, Waterbury  
 Ruby, R. J., Baylor '36, Waterbury  
 Russell, G. G., Harvard '19, Hartford  
 Russell, J. J., N. Y. Homeo. '87, Putnam  
 Russell, T. H., Yale '10, New Haven  
 Russell, W. I., Yale '09, New Haven  
 Russman, C., Tufts '23, Middletown  
 Russo, J. D., Yale '16, New Haven  
 Ryan, A. J., Columbia '40, Meriden  
 Ryan, F. J., Tufts '35, Hartford  
 Ryan, V. G., Yale '34, Portland  
 Ryder, C. F., Western Reserve '33, Stamford  
 Ryder, R. H., P. & S., Balt. '13, Waterbury  
 Ryder, W. H., Jefferson '20, New Haven  
 Ryley, R. N., Yale '39, Mystic  
 Rynard, W. M. W., Toronto '24, Stamford  
 Sabia, D. J., Marquette '36, Stamford  
 Sabloff, J., Long Island '34, Hartford  
 Sachs, B., N. Y. U. '37, Hartford  
 Sachs, K., Vienna '35, New Haven  
 Sadusk, J. F., Jr., Johns Hopkins '35, Orange, N. J. (New Haven County)  
 St. John, L. A., Fordham '20, Hartford  
 Salinger, R., Johns Hopkins '25, New Haven  
 Salter, W. T., Harvard '25, New Haven  
 Saltzman, J. A., N. Y. Homeo. '33, Waterbury  
 Salvin, B. L., George Washington '21, Hartford  
 Samponaro, N., Johns Hopkins '29, Torrington  
 Sanderson, R. V., Vermont '20, Winsted  
 Sandulli, G. R., Tufts '29, Waterbury  
 Sanford, C. E., Yale '06, Seattle, Wash. (New Haven County)  
 Santoro, G. M., Cornell '24, Waterbury  
 Saposnik, J. J., Howard '33, West Haven  
 Satti, C. J., Yale '23, New London  
 Saunders, A. I., Tufts '42, Roxbury, Mass. (New Haven County)  
 Saunders, G. R., Cornell '41, Old Saybrook  
 Sayers, D. O'C., Tufts '35, Topeka, Kansas (New Haven County)  
 Sayers, J. J., Tufts '35, Hartford  
 Scafarello, P. J., Tufts '26, Hartford  
 Scalzi, L. C., Bologna '37, Bridgeport  
 Scanlon, J. J., Georgetown '35, South Norwalk  
 Scanlon, T. F., Yale '07, Norwalk  
 Scarbrough, M. McR., Yale '07, New Haven  
 Schaefer, A. M., Yale '25, Hartford  
 Schaefer, J., Tufts '17, East Hartford  
 Schatten, S. S., N. Y. U. '31, West Hartford  
 Schechtman, C. T., Vermont '26, New Britain  
 Schiavetti, A., Tufts '30, Stafford Springs  
 Schillander, C. A., Tufts '09, Somers  
 Schmidt, N. L., Vanderbilt '27, Stamford  
 Schneider, W., George Washington '30, Rockville  
 Scholl, R. F., Yale '12, New Haven  
 Schopick, L. E., Zurich '35, Bridgeport  
 Schuman, D. H., Columbia '22, Hartford  
 Schupack, S. D., Tufts '24, New Britain  
 Schwartz, H. N., Med. Coll. of Va. '37, Hartford  
 Schwartz, P. E., Tufts '31, Portland  
 Schwarz, H. P., Vienna '38, Colchester  
 Sciortino, M. V., Naples '37, Bridgeport  
 Scott, C. R., Yale '19, New Haven  
 Scott, J. C., Pennsylvania '33, Essex  
 Scoville, D. H., Cincinnati '30, New London  
 Scoville, W. B., Pennsylvania '32, Hartford  
 Scully, M. R., Columbia '41, Bridgeport  
 Scully, R. T., Georgetown '35, New Britain  
 Seabury, R. B., Harvard '18, New Haven



- Sears, L., Harvard '29, Norwich  
 Segal, J. A., Tufts '28, Manchester  
 Segel, S., Vermont '35, Norwich  
 Segnalla, E., Yale '12, New Haven  
 Seibert, A. F., Yale '27, Hartford  
 Seideman, R. M., Long Island '36, Hartford  
 Sekerak, A. J., Maryland '22, Bridgeport  
 Sekerak, R. A., Maryland '29, Bridgeport  
 Sekerak, R. J., Maryland '34, Bridgeport  
 Selleck, N. B., Long Island '24, Danbury  
 Sellew, R. C., Yale '98, Canaan  
 Sellew, R. C., Jr., Long Island '36, Canaan  
 Senfield, M. M., Vienna '20, Ansonia  
 Serafin, P. J., N. Y. U. '21, New Haven  
 Serbin, A. F., Rush '33, Hartford  
 Serena, J. M., Hahnemann '41, South Norwalk  
 Serrell, H. P., Cornell '32, Greenwich  
 Sette, A. J., George Washington '27, Stamford  
 Sewall, S., Maryland '37, Elmwood  
 Shaffer, I. G., Jefferson '40, New Haven  
 Shain, J. H., Tufts '28, Norwalk  
 Shaw, G. H., Syracuse '08, Hartford  
 Shaw, L. E., Wom. Med. Coll. Pa. '22, Greenwich  
 Shay, F. L., Tufts '25, New Haven  
 Shea, C. J., Maryland '33, Bridgeport  
 Shea, D. E., Loyola '17, Hartford  
 Shea, J. F., P. & S., Balt. '11, Bridgeport  
 Shea, M. S., Vermont '21, New Haven  
 Shea, V. T., Tufts '31, Waterbury  
 Sheahan, W. L., P. & S., Balt. '12, New Haven  
 Sheehan, M. T., Yale '10, Wallingford  
 Sheiman, M., Michigan '39, Bridgeport  
 Sheiman, S. C., Michigan '40, Bridgeport  
 Shenker, B. M., N. Y. Med. Coll. '38, Middletown  
 Shepard, M. D., N. Y. U. '37, Hartford  
 Shepard, W. M., Columbia '29, Putnam  
 Shepherd, W. G., Toronto '08, Hazardville  
 Shermak, J. V., Vienna '19, Old Greenwich  
 Sherman, B., George Washington '29, Bridgeport  
 Sherman, S. H., Columbia '34, Stamford  
 Sherwood, H., N. Y. Med. '37, Middletown  
 Shirk, S. M., Hahnemann '97, Wallingford (Fairfield County)  
 Sholler, N. A., Hahnemann '43, Bridgeport  
 Shoup, H. B., Jr., Indiana '35, Westport  
 Shull, J. C., Harvard '36, Hartford  
 Shulman, D. N., Johns Hopkins '17, Hartford  
 Shumacker, H. B., Jr., Johns Hopkins '32, New Haven  
 Shupis, A., Jr., Hahnemann '38, Torrington  
 Shure, A. L., Tufts '27, New Haven  
 Siege, A. G., N. Y. Med. Coll. '43, Stratford  
 Sigal, H., Tufts '34, New Haven  
 Sigal, J. B., Yale '23, Hartford  
 Sikes, R. F., Yale '35, South Norwalk  
 Siliciano, R. A. V., Hahnemann '24, Bristol  
 Sills, T. H., Yale '27, Newington  
 Silver, G. B., Tufts '37, Hartford  
 Silverberg, S. J., Columbia '21, New Haven  
 Simmons, E. M., Yale '23, Southington  
 Simon, B., Washington '31, Middletown  
 Simon, L. G., N. Y. U. '27, South Norwalk  
 Simonds, J. R., Vermont '38, Washington  
 Simonton, F. F., Maine '03, Philadelphia, Penn. (Hartford County)  
 Simses, J. P., Tufts '37, Bridgeport  
 Sivak, G. C., Cincinnati '43, Ansonia  
 Skiff, S. E., Hahnemann '03, New Haven  
 Sklaver, J., Michigan '37, Waterbury  
 Slater, D., N. Y. Med. Coll. '40, Hamden  
 Slater, M., Yale '24, Hamden  
 Slavin, J. E., Vermont '12, Waterbury  
 Slossberg, D. S., Tufts '34, Hartford  
 Slys, L. B., Boston '27, New Britain  
 Smilgin, V. E., George Washington '38, New London  
 Smirnow, M. R., Yale '06, New Haven  
 Smith, A. C., P. & S., Balt. '10, Danbury  
 Smith, B. A., Yale '40, Norwich  
 Smith, C. L., N. Y. U. '41, Hartford  
 Smith, C. S., Hahnemann '16, New Haven  
 Smith, D. P., Yale '12, Meriden  
 Smith, E. L., Yale '96, Waterbury  
 Smith, E. R., Yale '40, Meriden  
 Smith, E. T., Yale '97, West Hartford  
 Smith, F. DeW., Hahnemann '10, Guilford  
 Smith, F. F., Howard '30, New Haven  
 Smith, F. M., Vermont '11, Willimantic  
 Smith, G. A., Johns Hopkins '07, Long Hill  
 Smith, G. M., Columbia '05, Pine Orchard, Branford  
 Smith, H. A., Yale '36, Bangor, Maine (Hartford County)  
 Smith, H. E., Columbia '15, Middlefield  
 Smith, J. A., Western Reserve '35, Waterbury  
 Smith, J. J., Maryland '30, Bridgeport  
 Smith, L. M., Tufts '37, Stamford  
 Smith, M., U. City N. Y. '83, New Haven  
 Smith, N. N., Yale '24, New Haven  
 Smith, P. L., Queens '19, Hartford  
 Smith, S. M., Tufts '20, Danbury  
 Smith, S. R., Med. Chi. Phila. '16, Bridgeport  
 Smith, V. J., Pennsylvania '20, New Britain  
 Smith, W. B., Pennsylvania '22, Hartford  
 Smith, W. E., Michigan '10, Stamford  
 Smith, W. F., Cornell '34, Hartford  
 Smith, W. L., Columbia '37, Hartford  
 Smykowski, B. L., P. & S., Balt. '11, Bridgeport  
 Snavely, J. G., Yale '41, Stamford  
 Snavely, M. E., Yale '25, West Haven  
 Sneiderman, G. I., Virginia '36, Hartford  
 Snelling, P. W., Harvard '21, Hartford  
 Snoke, A. W., Stanford '33, New Haven  
 Snurkowski, C. V., Georgetown '25, New Haven  
 Sohler, T. P., Freiburg '35, Hartford  
 Soifer, I. T., Creighton '26, Hartford  
 Sollosy, A., Tufts '27, Bridgeport  
 Solomkin, M., St. Louis '42, Chicago, Ill. (Hartford County)  
 Solomon, C. I., Yale '25, Meriden  
 Solomon, R. Z., Yale '39, Meriden  
 Soltz, T., Jefferson '11, New London  
 Solway, R. I., Toronto '40, Westport  
 Soreff, L., Tufts '32, East Hampton  
 Soresi, A. L., Naples '03, Stamford  
 Spector, N., Tufts '24, Willimantic  
 Speight, H. E., Georgetown '27, Middletown  
 Spekter, L., Rochester '33, Hartford  
 Spencer, S. B., N. Y. U. '41, Madison  
 Sperandeo, A., Yale '25, New Haven  
 Sperry, F. N., Yale '94, New Haven  
 Spicer, E., Yale '05, Waterbury  
 Spiegel, C. M., Hahnemann '36, New Haven  
 Spignesi, J. T., Georgetown '30, Wallingford  
 Spillane, B., Tufts '16, Hartford  
 Spinelli, N. V., Marquette '39, Bridgeport  
 Spinner, S., Tufts '35, New Haven  
 Sponzo, J. J., Tufts '38, Hartford  
 Sprague, C. H., Columbia '04, Bridgeport  
 Squier, R. R., Johns Hopkins '26, Greenwich  
 Squillacote, V. J., Rome '34, New Britain  
 Squillante, O. J., Maryland '40, Rockville

- Stahl, W. M., Maryland '14, Danbury  
 Standish, E. M., Harvard '22, Hartford  
 Standish, F. B., Yale '03, New Haven  
 Standish, H. C., Cornell '28, West Hartford  
 Standish, J. H., U. City N. Y. '95, Hartford  
 Standish, W. A., Yale '25, Hartford  
 Staneslow, J. S., Cornell '26, Waterbury  
 Stankard, W. F., Jefferson '38, Stamford  
 Starr, R. M., Yale '26, New London  
 Starr, R. S., Columbia '01, Hartford  
 Starrett, J. E., Tufts '30, Stamford  
 Staub, J. H., Long Island '99, Stamford  
 Steege, T. W., Yale '38, Hartford  
 Stein, J. D., Columbia '44, Milford  
 Steinberger, L., Royal Hungarian Eliz. '37, South Norwalk  
 Steincrohn, P. J., Maryland '23, Hartford  
 Stephens, D. C., Wayne '32, Newtown  
 Stephenson, C. W., Harvard '22, Hartford  
 Stetson, C. G., Cornell '35, Milford  
 Stetson, H. W., Vermont '06, Milford  
 Stettbacher, H. J., Harvard '22, Waterbury  
 Stevens, H. G., Maryland '04, New Milford  
 Stevens, M. A., Yale '29, New York, N. Y. (New Haven County)  
 Stevenson, W. R., Boston '31, Bristol  
 Stewart, H. E., Yale '10, New Haven  
 Stewart, L. Q., Yale '33, West Hartford  
 Stietzel, E. E., Columbia '34, South Norwalk  
 Stilson, C., Yale '42, New Haven  
 Stone, E. L., Johns Hopkins '20, New Haven  
 Stone, H. R., Johns Hopkins '04, Clinton  
 Stone, M. J., Rush '22, Stamford  
 Storms, W. F., Harvard '30, Wethersfield  
 Storrs, R. W., Harvard '20, Hartford  
 Strauss, M. J., Columbia '17, New Haven  
 Strayer, E. M., Columbia '33, Stratford  
 Strayer, L. M., Jr., Harvard '30, Bridgeport  
 Stretch, J. E., George Washington '28, Simsbury  
 Strickland, H., McGill '30, Meriden  
 Stringfield, O. L., Univ. & Bellevue '16, Stamford  
 Sturtevant, J. M., Bowdoin '14, New London  
 Stygar, J. S., St. Louis '33, Derby  
 Sullivan, A. B., Yale '38, West Hartford  
 Sullivan, A. F., Jefferson '42, Waterbury  
 Sullivan, C. N., McGill '30, New Britain  
 Sullivan, D., Univ. & Bellevue '97, New London  
 Sullivan, J. F., Columbia '94, New Haven  
 Sullivan, T. J., Yale '17, New Haven  
 Sulman, M., Columbia '36, New London  
 Sunderland, P. U., N. Y. Homeo. '94, Danbury  
 Sunderland, W. A., Yale '26, Danbury  
 Sundquist, A. B., Tufts '33, Manchester  
 Suplicki, J. W., Tufts '26, Norwich  
 Sussler, D., Fordham '16, Norwich  
 Sutch, G. C., Minnesota '41, Middletown  
 Sutherland, F. A., Harvard '26, Torrington  
 Sutton, P., Vienna '36, Groton  
 Swan, H. C., Tufts '03, Hartford  
 Swarts, W. B., Pennsylvania '34, Greenwich  
 Sweet, A. N., Maryland '18, Middletown  
 Sweet, J. H. T., Jr., Tufts '12, Hartford  
 Swenson, A. C., Yale '02, Waterbury  
 Swett, P. P., Univ. & Bellevue '04, Bloomfield  
 Swift, W. E., Jr., Columbia '40, New Haven  
 Swirsky, M. Y., N. Y. Med. Coll. '39, New Haven  
 Sword, B. C., N. Y. Homeo. '18, Yonkers, N. Y. (New Haven County)  
 Szlemko, E. A., Geneva '38, Groton  
 Taffel, M., Yale '31, New Haven  
 Tager, M., Yale '36, New Haven  
 Tait, A. A., Illinois '30, West Hartford  
 Talbot, H. P., Maryland '27, Hartford  
 Tanner, W. A., Vermont '12, Danielson  
 Tarasovic, T. J., Tufts '36, Bridgeport  
 Tarbell, L. A., Vermont '25, Batavia, N. Y. (New Haven County)  
 Tate, W. J., Yale '29, Deep River  
 Taylor, A., Rush '29, Hartford  
 Taylor, C. C., Harvard '16, Bridgeport  
 Taylor, H. C., Cornell '38, Meriden  
 Taylor, J. C., Michigan '91, New London  
 Taylor, R. M., George Washington '22, East Haven  
 Taylor, R. N., Yale '30, New London  
 Taylor, S. P., George Washington '16, North Haven  
 Teiger, P., Columbia '39, Waterbury  
 Tennant, R., Yale '29, Hartford  
 Terhune, W. B., Tulane '15, New Canaan  
 TerKuile, R. C., Rochester '32, Bridgeport  
 Teuscher, W. P., Tufts '32, Westport  
 Thalberg, R. E., Yale '26, Southington  
 Thayer, R. B., Bowdoin '20, Somers  
 Thenebe, C. L., Pennsylvania '18, West Hartford  
 Thomases, S., N. Y. U. '39, Stratford  
 Thompson, C. G., N. Y. Homeo. '18, Norwich  
 Thompson, H. G., Harvard '17, Hartford  
 Thompson, L. E., Boston '25, Meriden  
 Thompson, S. A., Cornell '23, Greenwich  
 Thompson, W. A. L., Yale '35, New Haven  
 Thoms, H., Yale '10, New Haven  
 Thomson, T. L., Hahnemann '01, Torrington  
 Thorne, L., Yale '36, New Haven  
 Throckmorton, V. J., Boston '33, Kingman, Arizona (Fairfield County)  
 Thumin, M., Maryland '33, Middletown  
 Tiebout, H. M., Johns Hopkins '21, Greenwich  
 Tileston, W., Harvard '99, New Haven  
 Timm, A. B., Jr., Harvard '40, Milford  
 Tinkess, D. E., McGill '25, Greenwich  
 Tirella, F. F., Tufts '37, Bristol  
 Tisher, P. W., Iowa '35, New Britain  
 Tissenbaum, M. J., Paris '36, New York City (New London County)  
 Todd, F. P., Boston '89, Danielson  
 Tokarczyk, J. J., Vermont '20, New Britain  
 Tolk, N. R., N. Y. U. '20, Bridgeport  
 Tomaino, F. F., Yale '29, Danbury  
 Tombari, S. P., Boston '34, Waterford  
 Tonken, L. C., Tufts '34, Hartford  
 Tortolani, A. P., McGill '34, Plainville  
 Tortora, F., Rome '40, New Haven  
 Tovell, R. M., Queen's '26, Hartford  
 Tower, A. A., Columbia '19, Meriden  
 Towne, N. A., Vermont '31, Naugatuck  
 Townsend, W. C., Harvard '25, Hartford  
 Tracey, E. J., Pennsylvania '24, Norwalk  
 Tracey, W. J., U. City N. Y. '89, Norwalk  
 Tracey, W. W., Columbia '16, Ft. Whipple, Arizona (Fairfield County)  
 Tracy, F. E., Yale '29, Middletown  
 Trantolo, A., Tufts '39, East Hartford  
 Trapp, F. W., Georgetown '36, New Britain  
 Trautman, E. F., Temple '40, Bridgeport  
 Treat, W. H., Yale '06, Derby  
 Trimpert, A. J., Georgetown '33, Bethel  
 Troy, W. D., Jefferson '36, Stamford  
 Truex, E. H., Louisville '08, Hartford



- Truex, E. H., Jr., Harvard '36, Hartford  
 Tuch, M., Univ. & Bellevue '06, Hartford  
 Tucker, C. A., Tufts '38, Hartford  
 Tunick, G. L., Jefferson '35, Greenwich  
 Turbert, E. J., P. & S., Balt. '04, Hartford  
 Turchik, F., Jefferson '27, Bridgeport  
 Turetsky, S., Baylor '36, Bridgeport  
 Turkington, C. H., Johns Hopkins '07, Litchfield  
 Turnley, W. H., Virginia '24, Stamford  
 Tutles, A. J., Tufts '30, Bridgeport  
 Twachtman, E., Virginia '36, New Canaan  
 Twaddle, P. H., Yale '35, Hartford  
 Tylec, L. L., Virginia '35, Naugatuck  
 Tyler, M., Johns Hopkins '17, New Haven  
 Tynan, J. G., Tufts '42, Waterbury  
 Unger, M., Hahnemann '37, Bridgeport  
 Unsworth, A. C., Vermont '31, Hartford  
 Upham, C. E. H., Pennsylvania '19, New Rochelle, N. Y. (Fairfield County)  
 Upson, W. H., Tufts '27, Suffield  
 Uricchio, J. G., Georgetown '31, Hartford  
 Urquhart, R. G., McGill '24, Norwich  
 Ursone, F. D., Tufts '29, Norfolk  
 Uvitsky, I. H., Boston '27, Bridgeport  
 Vail, G. F., Pennsylvania '02, Hartford  
 Vail, T. E., Johns Hopkins '11, Thompsonville  
 Valenski, T. J., Tufts '37, Thompsonville  
 Van Antwerp, L. D., Michigan '31, Chicago, Illinois (New Haven County)  
 Van Cor, C. A., Vermont '14, Middletown  
 Van Kleeck, E., Columbia '12, Hartford  
 Van Leuvan, J. S., Yale '27, Meriden  
 Van Strander, W. H., Vermont '00, Hartford  
 Van Tassel, W., N. Y. U. '27, Darien  
 Van Wart, W. H., Harvard '22, Hartford  
 Vastola, A. P., Fordham '12, Waterbury  
 Veal, W. T., Jefferson '12, Stonington  
 Vegliante, M. E., Tufts '27, New Haven  
 Veneruso, L. C., N. Y. Med. Coll. '42, Bridgeport  
 Verdi, W. F., Yale '94, New Haven  
 Vernlund, C. F., Harvard '14, Hartford  
 Vernon, S., Long Island '30, Willimantic  
 Vershbow, N., Tufts '19, Hartford  
 Verstandig, C. C., Tennessee '39, New Haven  
 Vestal, P. W., Harvard '22, New Haven  
 Vetrano, S. A., Naples '37, New Britain  
 Vickers, J. L., Johns Hopkins '24, Greenwich  
 Vinci, V. J., N. Y. U. '39, Middletown  
 Viola, C. P., Tufts '36, Milford  
 Vioni, R. E., Naples '35, Bridgeport  
 Vogel, F. S., Vienna '27, Bristol  
 Vollero, A., Tufts '30, New Haven  
 Vollmer, J. W., Yale '06, Norwalk  
 von Glahn, H. D., Duke '42, Old Lyme  
 Voris, J. V. B., Columbia '41, Darien  
 Wadhams, S. H., Yale '96, Torrington  
 Wadsworth, R. F., Cornell '19, New Canaan  
 Wagner, H. T., Jr., Indiana '37, Indianapolis, Indiana (New Haven County)  
 Wakeman, E. T., Yale '22, New Haven  
 Waldemar-Kertész, J., Vienna '26, New Haven  
 Wales, F. J., Univ. & Bellevue '97, Stepney Depot  
 Walker, D. A., Tufts '38, Rocky Hill  
 Walker, R., Rochester '37, Hartford  
 Walker, W. B., Yale '20, Cornwall  
 Walker, W. H., Harvard '03, Newtown (Hartford County)  
 Wallace, C. K., Queens '13, Hartford  
 Wallace, V. G. H., Edinburgh '26, Norwalk  
 Wallach, G. M. K., Berne '39, Torrington  
 Walton, L. L., Johns Hopkins '33, West Hartford  
 Ward, J. P., Georgetown '36, Bridgeport  
 Ward, J. W., P. & S., Balt. '07, South Glastonbury  
 Ward, L. S., Cornell '31, New London  
 Warner, C. N., Jr., Tufts '36, Litchfield  
 Warner, G. H., Yale '97, Bridgeport  
 Warren, H. F., Vanderbilt '15, New London  
 Warren, H. S., Harvard '36, Wethersfield  
 Warring, H. L., Howard '28, Hartford  
 Washburn, W. J., Indiana '21, Stamford  
 Waskovitz, D., Yale '20, New Britain  
 Waterman, C., McGill '05, Middletown  
 Watson, R. W., Wisconsin '38, Manchester  
 Watson, W. J., N. Y. U. '31, New Britain  
 Watts, J. F., Georgetown '12, Bridgeport  
 Wawro, N. W., Yale '38, Hartford  
 Weadon, W. L., Med. Coll. of Va. '05, Bridgeport  
 Weaver, B. S., Michigan '10, Stamford  
 Webber, E. R., Jefferson '14, Waterbury  
 Weber, F. C., Jr., Johns Hopkins '36, Greenwich  
 Weed, C. A., Harvard '42, New York City (New Haven County)  
 Weed, F. A., Albany '12, Torrington  
 Wehger, R. T., Yale '32, Bridgeport  
 Weidman, W. H., McGill '31, Norwich  
 Weigle, L. A., Jr., Yale '39, Newport, N. H. (Hartford County)  
 Weil, A., Univ. & Bellevue '14, New Haven  
 Weile, F. W., Breslau '22, Naugatuck  
 Weiner, J. G., Yale '29, Hartford  
 Weiner, S., Columbia '35, Hartford  
 Weiner, W., Tufts '38, Danbury  
 Weinstein, N., Trinity (Dublin) '34, Norwalk  
 Weir, M. L. B., Johns Hopkins '22, New Haven  
 Weise, E. C., Jefferson '20, Bridgeport  
 Weisenfeld, N., Maryland '28, Hartford  
 Weissenborn, W., Johns Hopkins '32, Hartford  
 Welch, H. L., Yale '97, New Haven  
 Weld, S. B., Harvard '16, Hartford  
 Wellington, H. W., Columbia '13, New London  
 Wells, D. B., Johns Hopkins '12, Hartford  
 Wells, E. C., Women's Med. Coll. Pa. '12, Hartford  
 Wells, J., Yale '37, West Hartford  
 Welt, L. G., Yale '38, Washington, D. C. (Windham County)  
 Wener, W. V., McGill '27, Norwich  
 Wentworth, J. A., Harvard '13, West Hartford  
 Wentworth, J. H., Yale '39, Cambridge, Mass. (New Haven County)  
 Wersebe, F. W., Univ. & Bellevue '98, Washington  
 Wertheimer, J., Univ. & Bellevue '18, Waterbury  
 Whalen, E. J., Yale '08, Hartford  
 Whalley, E. J., Tufts '43, Waterbury  
 Whalin, M. L., Women's Med. Coll. Pa. '35, Storrs  
 Wheatley, L. F., Tufts '03, New Haven  
 Whipple, B. N., Yale '07, Bristol  
 Whitcomb, B. B., McGill '35, Hartford  
 White, B. V., Harvard '34, Hartford  
 White, E. P., Vermont '37, Hartford  
 White, H. T., Western Reserve '34, Meriden  
 White, J. C., Harvard '29, New Britain  
 White, R. L., Eclectic, Missouri '12, New Canaan  
 Whiting, H. St. J., McGill '21, Middletown  
 Whiting, L. C., Md. Coll. Med. '12, New Haven  
 Whiting, R. C., McGill '24, Hartford

- Whittles, L. J., Columbia '21, Glastonbury  
 Whitty, C. A., Queens '29, Hartford  
 Wiedman, O. G., Pennsylvania '05, Hartford  
 Wieler, H. J., Columbia '28, Lakeville  
 Wienski, J. C., Hahnemann '21, Hartford  
 Wiepert, W. M., Yale '37, Avon  
 Wies, C. H., Yale '32, New London  
 Wies, F. A., Yale '33, New Haven  
 Wight, W. E., Bowdoin '20, Thomaston  
 Wilcox, F. C., Medical Evangelists '34, Waterbury  
 Wilcox, L. M., Tufts '33, Terryville  
 Wilder, E. A., Boston '23, Middletown  
 Wilk, E. K., Baylor '36, Middletown  
 Wilkinson, A. G., Maryland '36, New Haven  
 Willard, W. R., Yale '34, New Haven  
 Williams, C. M., Columbia '08, Nassau, B. W. I. (New London County)  
 Williams, E. E., Columbia '23, Naugatuck  
 Williams, F. P. A., N. Y. Med. Coll. '44, Monroe  
 Willis, T., Yale '36, Norwalk  
 Willner, O., Vienna '05, New Haven  
 Wills, A. A., Jr., Yale '31, Hartford  
 Wilson, A. C., Toronto '34, Hartford  
 Wilson, C. C., Yale '28, New Haven  
 Wilson, D. E., Jefferson '30, New Britain  
 Wilson, F. E., Vermont '11, New London  
 Wilson, G. C., Yale '28, Waban, Mass. (New Haven County)  
 Wilson, H. M., Washington '27, New Haven  
 Wilson, J. A., Jefferson '19, Meriden  
 Wilson, W. A., Louisville '28, Hartford  
 Wilson, W. R., Johns Hopkins '25, New Haven  
 Wineck, M. S., Vermont '15, Hartford  
 Winer, P., St. Louis '44, New Haven  
 Winne, W. N., Univ. & Bellevue '97, New Haven  
 Winternitz, M. C., Johns Hopkins '07, New Haven  
 Winters, H. W., Johns Hopkins '29, Bristol  
 Winters, J. T., Pennsylvania '31, Hartford  
 Winters, S., Baylor '20, New Haven  
 Witter, O. R., Columbia '01, Hartford  
 Wolfson, D., Boston '33, Bethel  
 Wood, F. O., Rush '31, Hartford  
 Wood, H. C., 3rd, Pennsylvania '38, Peoria, Illinois (Fairfield County)  
 Woodford, C. N., Louisville '08, Hartford  
 Woodford, F. B., Yale '24, Ridgefield  
 Woodruff, L. M., Yale '37, Boston, Mass. (New Haven County)  
 Woodward, H. B., Johns Hopkins '12, Bristol  
 Woodward, J. C., Columbia '35, New London  
 Woodworth, J. A., Syracuse '39, Moosup  
 Worthen, T. W., Dartmouth '11, Hartford  
 Wrang, W. E., Jefferson '19, Middletown  
 Wray, E. H., Jr., Yale '32, Litchfield  
 Wright, W. W., Harvard '19, Hartford  
 Wrona, E. A., Hahnemann '43, Stamford  
 Wulp, G. A., Michigan '30, Hartford  
 Wurtenberg, W. C., Yale '93, New Haven  
 Yanner, H., Yale '29, Southbury  
 Yasser, I., Colorado '40, Bridgeport  
 Yavis, J. C., Athens '18, New Haven  
 Yeager, C. F., Hahnemann '33, Bridgeport  
 Yerbury, C. C., N. Y. Med. '16, Manchester  
 Yerbury, E. C., Boston '21, Middletown  
 Yergason, R. M., Columbia '09, Hartford  
 Yoburn, M. M., Boston '39, Danbury  
 Yohn, A. K., Columbia '35, Washington, D. C. (Fairfield County)  
 Young, W. G., Toronto '30, Hartford  
 Yudkin, A. M., Yale '17, New Haven  
 Zaff, F., Michigan '37, New Haven  
 Zaglio, E. R., Columbia '33, Manchester  
 Zariphes, C. A. P., Boston '24, Hartford  
 Zarkin, O. H., Tufts '37, Hartford  
 Zaur, I. S., Yale '32, Bridgeport  
 Zavadier, N., Zurich '18, Bridgeport  
 Zeman, B., Kentucky '08, Hartford  
 Zeman, M. S., Louisville '36, Hartford  
 Zerkowitz, F., Graz '22, Waterbury  
 Zielinski, J. B., Jefferson '34, Bridgeport  
 Zimmerman, H. M., Yale '27, New York, N. Y. (New Haven County)  
 Zonn, S. I., Tufts '17, Waterbury  
 Zsiga, E. D., Marquette '38, Bridgeport  
 Zwick, F., Vermont '13, New Britain

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- Burr, H. S., New Haven  
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 Hiscock, I. V., New Haven  
 Long, C. N. H., New Haven  
 Mickle, F. L., Hartford  
 Schneider, E. C., Middletown



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# *The* CONNECTICUT STATE MEDICAL JOURNAL

Vol. XI

SEPTEMBER, 1947

No. 9

TWENTY-SECOND CLINICAL CONGRESS  
OF THE  
CONNECTICUT STATE MEDICAL SOCIETY  
AND THE  
YALE SCHOOL OF MEDICINE

YALE LAW SCHOOL AUDITORIUM  
Grove Street, New Haven

NEW HAVEN HOSPITAL AND THE SCHOOL OF MEDICINE  
Cedar Street, New Haven

SEPTEMBER 16, 17, 18, 1947

## PROGRAM

Tuesday, September 16

### MORNING SESSION, AUDITORIUM OF THE LAW SCHOOL

- 10:00 THE MANAGEMENT OF PATIENTS WITH ANURIA  
Edward L. Pratt, *New Haven, National Research Council Senior Fellow in Pediatrics, Grace-New Haven Community Hospital*
- 10:15 THERAPEUTIC ADVANTAGE OF COMBINATIONS OF SULFONAMIDES  
William T. Salter, *New Haven, Professor of Pharmacology, Yale School of Medicine; Chairman, Pharmacy Committee of the Grace-New Haven Community Hospital*
- 10:30 VAGOTOMY IN THE TREATMENT OF PEPTIC ULCER  
Lester R. Dragstedt, *Chicago, Chairman, Department of Surgery, University of Chicago School of Medicine; Attending Surgeon, Albert Merritt Billings Hospital*
- 11:00 PSYCHIATRY IN A GENERAL HOSPITAL  
M. Ralph Kaufman, *New York, Chief Psychiatrist, The Mount Sinai Hospital*
- 11:40 PENICILLIN IN THE TREATMENT OF SYPHILIS  
Frank W. Reynolds, *Baltimore, Instructor in Medicine, Johns Hopkins University School of Medicine; Assistant Physician, Johns Hopkins Hospital*
- 12:10 THE TREATMENT OF SYPHILIS OF THE NERVOUS SYSTEM  
Raymond D. Adams, *Boston, Assistant Professor of Neurology, Harvard Medical School; Visiting Neurologist and Neuropathologist, Boston City Hospital*
- 1:15 LUNCHEON, New Haven Hospital; Discussion period

## Tuesday, September 16

EACH AFTERNOON DURING THE CONGRESS, A SERIES OF PANEL DISCUSSIONS, SYMPOSIA AND DEMONSTRATIONS WILL BE PRESENTED AT THE NEW HAVEN HOSPITAL AND THE SCHOOL OF MEDICINE. SPEAKERS AT THE MORNING SESSIONS WILL PARTICIPATE IN THESE DISCUSSIONS

2:30 P. M.

### FARNAM AMPHITHEATER

#### PANEL DISCUSSION ON NEW DEVELOPMENTS IN THE SURGICAL MANAGEMENT OF PEPTIC ULCER

Samuel D. Kushlan, *New Haven, Chairman*

Lester R. Dragstedt, *Chicago*

Ralph Colp, *New York*

### BRADY AUDITORIUM

#### PANEL DISCUSSION ON THE TREATMENT OF SYPHILIS

Allan K. Poole, *New Haven, Chairman*

Frank W. Reynolds, *Baltimore*

Raymond D. Adams, *Boston*

Francis G. Blake, *New Haven*

Paul D. Rosahn, *New Britain*

### FITKIN AMPHITHEATER

#### SYMPOSIUM ON DIARRHEA IN INFANCY

Daniel C. Darrow, *New Haven, Chairman*

Edward L. Pratt, *New Haven*

Joseph L. Hetzel, *Waterbury*

James J. Flett, Jr., *New Haven*

3:45 P. M.

### FITKIN AMPHITHEATER

#### PANEL DISCUSSION ON PSYCHIATRY IN THE GENERAL HOSPITAL

Burness E. Moore, *New Haven, Chairman*

Maxwell Pasternak, *New Haven*

James M. Cunningham, *Hartford*

M. Ralph Kaufman, *New York*

### BRADY AUDITORIUM

#### SYMPOSIUM ON OCCUPATIONAL DISEASE

Ronald F. Buchan, *New Haven, Chairman*

Willard F. Machle, *New York*

Roy M. Seideman, *Hartford*

William T. Salter, *New Haven*

C. Frederick Yeager, *Bridgeport*

## Wednesday, September 17

### MORNING SESSION, AUDITORIUM OF THE LAW SCHOOL

#### 10:00 A PRACTICAL APPROACH TO THE PROBLEM OF EPIDEMIC RINGWORM OF THE SCALP

Samuel M. Peck, *New York, Chief Dermatologist, The Mount Sinai Hospital, Consultant, United States Public Health Service*

#### 10:30 THE VALUE OF THE VAGINAL SMEAR IN THE DIAGNOSIS OF UTERINE CANCER

Howard Ulfelder, *Boston, Instructor in Surgery, Harvard Medical School; Assistant Surgeon, Massachusetts General Hospital*



1:00 CONGENITAL LESIONS OF THE GASTROINTESTINAL TRACT CAUSING OBSTRUCTION

Orvar Swenson, *Boston, Associate in Surgery, Harvard Medical School; Surgeon, The Children's Hospital*

1:40 THE DIAGNOSIS OF OPERABLE CONGENITAL CARDIAC LESIONS

Ruth Whittemore, *New Haven, Assistant Clinical Professor of Pediatrics, Yale School of Medicine; Director, New Haven Rheumatic Fever and Cardiac Program*

2:10 MODERN TREATMENT OF THYROTOXICOSIS

J. H. Means, *Boston, Jackson Professor of Clinical Medicine, Harvard Medical School; Chief of the Medical Services, Massachusetts General Hospital*

2:15 LUNCHEON, New Haven Hospital; Discussion period

AFTERNOON SESSIONS

2:30 P. M.

FARNAM AMPHITHEATER

GENERAL DISCUSSION ON THE DIAGNOSIS OF UTERINE CANCER

Carl E. Johnson, *New Haven, Chairman*

Howard Ulfelder, *Boston*

Louis F. Middlebrook, *Hartford*

Ralph E. Kendall, *Hartford*

Arthur H. Morse, *New Haven*

FITKIN AMPHITHEATER

SYMPOSIUM ON THE TREATMENT OF CONGENITAL CARDIOVASCULAR ANOMALIES

Harris B. Shumacker, Jr., *New Haven, Chairman*

Ruth Whittemore, *New Haven*

Arthur J. Geiger, *New Haven*

Hugh M. Wilson, *New Haven*

Frank D. Gray, Jr., *New Haven*

BRADY AUDITORIUM

SYMPOSIUM ON THYROTOXICOSIS

William T. Salter, *New Haven, Chairman*

Edward Rose, *Philadelphia*

J. H. Means, *Boston*

Barnett Greenhouse, *New Haven*

3:45 P. M.

FARNAM AMPHITHEATER

PRESENTATION OF SURGICAL CASES

Samuel C. Harvey, *New Haven, Chairman*

William J. German, *New Haven*

Harris B. Shumacker, Jr., *New Haven*

Gustaf E. Lindskog, *New Haven*

Max Taffel, *New Haven*

BRADY AUDITORIUM

THE ANTIBIOTICS IN RELATION TO THE SKIN

Maurice J. Strauss, *New Haven, Chairman*

E. Myles Standish, *Hartford*

Samuel M. Peck, *New York*

Ellwood C. Weise, *Bridgeport*

## Wednesday, September 17 (Continued)

### FARNAM AMPHITHEATER

#### PANEL DISCUSSION ON ROOMING-IN FOR MOTHERS AND INFANTS AT GRACE-NEW HAVEN COMMUNITY HOSPITAL

Edith B. Jackson, *New Haven, Chairman*  
 Herbert Thoms, *New Haven, Co-Chairman*  
 Alan Foord, *New Haven*  
 Richard W. Olmsted, *New Haven*

Miss Kate Hyder, *New Haven*  
 Mrs. Edward T. Krementz, *New Haven*  
 Mrs. William Helmuth, *New Haven*  
 Mrs. Gibson Danes, *Hamden*

### FITKIN AMPHITHEATER

MOTION PICTURE: "To Hear Again," Norton Canfield, *New Haven*

4:30 P. M.

### SOCIAL HOUR

BEAUMONT ROOM OF THE HISTORICAL LIBRARY  
 Sterling Hall of Medicine

6:30 P. M.

The Hezekiah Beardsley Pediatric Club will hold a dinner meeting at the New Haven Medical Association, 364 Whitney Avenue. The name of the speaker and his subject will be announced at a later date.

## Thursday, September 18

### MORNING SESSION, AUDITORIUM OF THE LAW SCHOOL

#### 10:00 THE DIAGNOSIS OF BRUCELLOSIS

Wesley W. Spink, *Minneapolis, Professor of Medicine, University of Minnesota Medical School; Staff Member, University of Minnesota Hospitals*

#### 10:30 BOECK'S SARCOID

I. Snapper, *New York, Director of Medical Education, The Mount Sinai Hospital*

#### 11:00 THE VALUE AND LIMITATIONS OF LIVER FUNCTION TESTS

Franklin M. Hanger, *New York, Professor of Medicine, Columbia University College Physicians and Surgeons; Attending Physician, Presbyterian Hospital*

#### 11:40 THE DIAGNOSIS AND TREATMENT OF ANEMIA

William Dameshek, *Boston, Professor of Clinical Medicine, Tufts College Medical School; Senior Attending Physician and Hematologist, Joseph H. Pratt Diagnostic Hospital*

#### 12:10 PSYCHIATRY IN GENERAL PRACTICE AND IN PSYCHIATRIC PRACTICE

John Milne Murray, *Boston, Professor of Clinical Psychiatry, Boston University School of Medicine*

#### 1:15 LUNCHEON, New Haven Hospital; Discussion period



## AFTERNOON SESSIONS

2:30 P. M.

## BRADY AUDITORIUM

## PANEL DISCUSSION ON INFECTIOUS DISEASES

Francis G. Blake, *New Haven, Chairman*Charles A. Janeway, *Boston*Edward C. Curnen, *New Haven*Wesley Spink, *Minneapolis*Robert H. Green, *New Haven*William S. Tillett, *New York*John R. Paul, *New Haven*Paul L. Boisvert, *New Haven*Kirby S. Howlett, Jr., *Shelton*

## FARNAM AMPHITHEATER

## PANEL DISCUSSION ON LIVER DISEASE

Gerald Klatskin, *New Haven, Chairman*Franklin M. Hanger, *New York*

Other participants to be announced

## MEDICAL AMPHITHEATER

## SYMPOSIUM ON PSYCHOTHERAPY

Frederick C. Redlich, *New Haven, Chairman*Helen Richter Gilmore, *New Haven*John Milne Murray, *Boston*Martin Heinemann, *New Haven*Richard Newman, *New Haven*

3:45 P. M.

## BRADY AUDITORIUM

## SYMPOSIUM ON PULMONARY GRANULOMAS

Kirby S. Howlett, Jr., *Shelton, Chairman*I. Snapper, *New York*Averill A. Liebow, *New Haven*Hugh M. Wilson, *New Haven*Gustaf E. Lindskog, *New Haven*

## FARNAM AMPHITHEATER

## PANEL DISCUSSION ON ANEMIA

Theodore S. Evans, *New Haven, Chairman*Luis Amill, *New York*William Dameshek, *Boston*Nathan Rosenthal, *New York*

## MEDICAL AMPHITHEATER

## MOTION PICTURE AND DISCUSSION ON REGENERATION OF VISION

Leon S. Stone, *New Haven*

2:30 P. M.

## ROOM B305, STERLING HALL OF MEDICINE

## SECTION ON ANESTHESIOLOGY

Stevens J. Martin, *Hartford, presiding*

## TOPICAL AND INTRAVENOUS ANESTHESIA FOR INTRATRACHEAL INTUBATION

John M. Schwab, *Hartford*

## Thursday, September 18

### 2. INTRAVENOUS PROCAINE BELOW TOURNIQUET FOR SURGERY OF THE EXTREMITIES

Samuel Wolfson, *New Britain*

### 3. ANESTHESIA FOR RECTAL SURGERY

Carl S. Hellijas, *Hartford*

### 4. BUSINESS MEETING OF THE SECTION

The Alumni of the New Haven Hospital Staff are invited to be the guests of the Resident Staff, New Haven Unit of Grace-New Haven Community Hospital, at a buffet supper in the Doctor's Lounge Thursday, September 18, at 6:00 P. M.

## COMMITTEE ON THE CLINICAL CONGRESS

Francis G. Blake, *Chairman*

Herbert Thoms, *Secretary*

Cole B. Gibson, *Treasurer*

Courtney C. Bishop, *Arrangements*

Harris B. Shumacker, Jr.

Arthur J. Geiger, *Program*

Hugh M. Wilson

Frederick C. Redlich

William R. Wilson

## General Information

### REGISTRATION FEE

The registration fee for members of the Connecticut State Medical Society is \$3.00. The fee for non-members is \$5.00. Payment of the registration fee will admit to all sessions of the Congress.

Hospital residents, interns and medical students will be admitted to sessions without charge if a statement of their position, signed by an official of the hospital or medical school, is presented at the registration desk.

### MEETING PLACE

The morning sessions will be held in the auditorium of the Law School, Grove and York Streets, New Haven. The afternoon panels and symposia will be held in the amphitheaters of the New Haven Hospital and the School of Medicine.

### TELEPHONE

All telephone messages will be received at New Haven 7-0877.

### LUNCHEONS

Cafeteria luncheons will be served at the New Haven Hospital on the three days of the Congress. The number of persons who can be served is limited and reservations should be made in advance.

### PARKING

Parking of automobiles is restricted in the vicinity of the Law School and New Haven Hospital. Stickers for windshields will be provided.



## REGISTER EARLY

Early registration will facilitate the work of the committee and save time for you at the Congress. The registration and luncheon reservation card which will be mailed with the advance program should be filled out and returned with the registration fee as soon as possible.

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**Landmarks In Medicine Through the Ages**

The Yale Medical Library in anticipation of the Connecticut Clinical Congress is exhibiting through the month of September some of its rare volumes and important landmarks in the history of medicine from the early beginnings in Egypt, Greece, and Rome down to the present day. Representative works of Galen and Hippocrates are followed by examples of the cradle books of the 15th century with Hartmann Schedel's copy of Pietro d'Abano's *Conciliator* (Mantua, 1472) as one of the highlights (it is also the oldest printed volume in the Historical Library). Several herbals, including Peter Schoeffer's 1485 edition of the *Gart der Gesundheit*, are included among the incunabula on display.

The 1543 *Fabrica* of Vesalius, the cornerstone of modern anatomy, and the rare surgical octavos of Ambroise Paré have been selected for the 16th century, one of the most precious of the latter being *La manière de traicter les playes* (Paris, 1551), printed on vellum. Famous publications of the 17th century include the first edition of Harvey's *De motu cordis* of 1628, Malpighi's discovery of the capillaries (*De pulmonibus*, 1661), Robert Boyle on the *Spring and Weight of the Air* (1660), Sydenham on Fevers (1666), Robert Lower on the Heart (*Tractatus de corde*, 1669), and John Mayow's celebrated studies on Respiration (*Tractatus Quinque*, 1674).

In the 18th century Priestley's (1775) and Lavoisier's (1775) papers on the discovery of oxygen are featured, as are also the first edition of Fothergill's report in 1748 on "Ulcerated Sore Throat" (Diphtheria) and of Edward Jenner's report fifty years later on Vaccination. Eighteenth century surgery is represented by John Hunter's books on Inflammation and Gunshot Wounds. The *Inventum novum* of Auenbrugger (1761) recording for the first time the use of percussion of the chest in diagnosis is also shown.

The 19th century has a larger selection, including Laennec on Auscultation (1819) which introduced the use of the stethoscope, John Bright's Reports of Medical Cases (1827) in which acute glomerular nephritis was first described (Bright's disease), Addison on Diseases of the Suprarenals (Addison's Disease, 1855), Pasteur's discovery of the bacteria, Lister on the antiseptic principle, Robert Koch on Wound Infections, Laveran on Malaria, and finally Röntgen's 8-page pamphlet announcing the discovery of x-rays.

Highlights in the 20th century include Domagk's initial paper on the sulphonamids, the work on Penicillin by Florey and his group at Oxford, on Streptomycin by Waksman, and the studies of Trueta's group, also at Oxford, on the Renal Circulation published on July 21, 1947 for the 17th International Physiological Congress.

## THE STUDY OF STERILITY

WALTER W. WILLIAMS, M.D., *Springfield, Massachusetts*

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The Author. *Geneticist, Springfield Hospital*

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THE STUDY of sterility as carried on during the past few years has been marked by a more widespread realization of the complexity of the problems involved and the necessity of a comprehensive survey covering the most important etiological features as related to both partners. Such a diagnostic survey has come to include a general health survey, various types of examinations of the generative organs, and tests which give an index to the health of the germ plasm of each sex. Amongst those who are attempting comprehensive studies of infertility, the investigation usually commences with an analysis of a bottle specimen of semen, which includes a study of spermiatic pathology as well as motility and sperm concentration. If it is considered that fertilization is possible from the husband's semen, one proceeds in a systematic manner with the other steps in the general diagnostic agenda, including the various examinations concerning the fertility of the wife. If the husband right at the start is considered as totally sterile, the decision should at once be made between hetero-insemination, adoption, or the cancellation of all further efforts to have a family. When hetero-insemination is the course of election, it is first usually wise to make such examinations of the wife that one may be reasonably assured of her fertility.<sup>1,2</sup>

There is a definite trend to base treatment more upon objective findings, a trend which is often pretty well obscured by the popular effort to explain most sterility on some glandular dysfunction and to empirically treat sterility on that basis without any effort in the matter of diagnosis. A failure to make an effort at an endocrine diagnosis is rather inexcusable, for although admittedly inadequate, various tests do give a rough idea of glandular activity and furnish some objective basis for therapy. The effect of estrogen elaboration may be roughly indicated by such tests as:

1. Schiller's Test.<sup>3</sup>

2. Staining of vaginal smears for glycogen.<sup>4</sup>
3. Staining for cornification of vaginal cells by Papanicolaou's method.<sup>5</sup>
4. Urinary hormone analysis.<sup>6</sup>
5. Endometrial biopsy.<sup>7</sup>

The effect of progesterone elaboration may be indicated by such tests as:

1. Basal body temperature curves.
2. Endometrial biopsies.
3. Urinary hormone assay.

Nearly twenty per cent of the cases of infertility, both male and female, have a low basal metabolic rate, and it is therefore considered that a determination of the basal metabolic rate is desirable in all routine infertility studies.<sup>8</sup> There is little doubt of the effectiveness of thyroid therapy in many instances where a lack of normal ovulation is associated with a low basal metabolic rate, but by and large, the negative results with the various gonadotropic hormones do not commend their use in the correction of pathologic ovulation or anovulation.

With proper planning and grouping, comprehensive diagnostic surveys on infertile couples should be completed in the matter of four or five visits by the wife and one visit by the husband, covering a period of not more than four to five months. Where such studies are being conducted, it is generally considered advisable to clear up the diagnostic work promptly, and defer all but incidental treatment until the diagnostic work on both partners has been completed. If this is done, much expensive and needless treatment will be avoided. For diagnostic programs and technique, one should refer to such comprehensive treatises as those by Lane-Roberts,<sup>9</sup> Siegler,<sup>10</sup> Weisman,<sup>11</sup> Hotchkiss,<sup>12</sup> and to various current publications on the subject.

### THE STATUS OF SEMEN EXAMINATIONS AND INTERPRETATIONS

The problem of semen analysis is in general in a highly unsatisfactory condition both from the viewpoint of technique and interpretation. Only too



requently that which is considered as a significant abnormality is a matter of opinion rather than the result of collated evidence from clinical studies. This, together with faulty and inadequate observations, often throws much doubt on the validity of the interpretation of many semen examinations. Male fertility is largely dependent upon the availability of normal spermatozoa at the time of ovulation.<sup>13,14</sup> Normal semen ordinarily contains a superabundance of normal spermatozoa so that only a small fraction of a normal ejaculated specimen is necessary for insemination and fertilization. In cases of infertility due to male germinal disease, and most male infertility falls into this category, the quality of spermatozoa is subnormal. This condition is commonly distinguished by a lessened motility and by an increase in the number of spermatozoa presenting morphologic abnormalities. Back of these changes, there is commonly a disturbance of the primitive germ plasma which may lessen the rate of spermatogenesis, and consequently cause a lowered sperm concentration in the ejaculated semen. A common error in semen examination and interpretation is to rely too much on the state of motility as evidence of potential fertilizing ability or to evaluate the specimen on the basis of the number of spermia present without consideration of their quality. Occasional conceptions will occur from sperm populations containing more than 50 per cent pathologic spermatozoa, irrespective of the sperm concentration; but fertility wanes greatly long before this point is reached.

Although true that pathologic germ plasma is often incapable of forming normal numbers of spermatozoa and that pathologic spermatozoa are certainly more apt to possess low motility, or no motility at all, it frequently happens that sperm populations of normal motility and concentration are composed of pathologic cells which are fundamentally infertile. In such instances, the customary semen examination, depending upon sperm concentration, motility, and semen volume, will fail in the recognition of the cause of the infertility. If one is to pass upon the state of fertility of the male, he should be acquainted with proper staining methods for bringing out significant spermatoc pathology, he should be sufficiently acquainted with spermatoc cytology to enable the recognition of pathology, and further be provided with a microscope with sufficient magnification and resolving power so that the pathology when present may be observed.

For a great many years, Huhner tests, or post-coital examinations for the presence of live spermatozoa in the female tract have been considered by many as the most satisfactory means, or the only means by which the fertility of the male might be estimated.<sup>15</sup> The value of the Huhner test in this respect hypothecates that the fertility of the male is roughly in line with the quality of these tests, thus the conception rate should increase or fall with the incidence of highly motile spermatozoa that are found in the cervical canal at a given time after coitus. Its value is based largely upon the correctness of the premise that the favorable alkaline secretion at the time of ovulation is less favorable for the spermatozoa that are incapable of fertilizing an ovum than for other members of the sperm population. When evaluating Huhner tests, it seems hardly necessary to consider the many cases in which the initial semen examination reveals low motility, no motility, no spermia or very few spermia in the ejaculate, or the many instances in which the high incidence of pathologic spermatozoa places them already into the definitely sterile group. The study of known sterile males is hardly enhanced by mixing their semen with the mucus of the cervical canal. With other cases, there is considerable difference of opinion as to just how many spermatozoa should be found in the cervical canal and how motile they should be to indicate fertility. It is generally contended that if the tests are to be of value, they should be conducted at a given time in the cycle, and at a given number of hours after coitus. An analysis of these two factors reveals that the day of the cycle or the number of hours after coitus (between 5 and 15 hours) makes no significant difference in the ratio of positive and negative tests.<sup>16,17</sup> If the standard for a satisfactory test is fixed too low, say 1 to 5 motile spermia per high power field, one will find that almost all cases of sterility will give positive tests at one time or another provided that an abundance of motile spermatozoa are present in the seminal fluid at the time of coitus. If a higher standard is fixed for a normal test, one will wonder why so many conceptions occur with such poor tests. Actually, motility and fertilizing ability are far from synonymous in meaning, for it happens that most infertile spermatozoa possess motility that cannot be distinguished from the motility commonly credited to the more healthy spermatozoa, and further that if fertile spermatozoa are present in an ejaculate, conception occurs fre-

quently without any mass migration of spermatozoa through the cervical canal. After having witnessed large aggregations of defective spermatozoa in the cervical secretions, one is led to wonder if a large and persistent sperm aggregation at this point might constitute an evidence of infertility, rather than fertility as commonly interpreted.

The lack of proper standards for the evaluation of post-coital tests and the frequency of highly satisfactory intra-cervical motility with cases that are obviously sterile, often brings up the validity of conclusions based upon the Huhner test alone. This suggests that the Huhner test should be much more carefully evaluated in connection with the pathology of the female tract and that of the semen, and that it should be considered merely as part of the diagnostic study to determine the influence of the male upon fertility, rather than as a substitute for the direct examination of semen as is so frequently done in sterility investigations.

Another apparent misconception concerns the effect of semen volume and sperm concentration upon fertility. The volume seems to be significant only when so small that it interferes with cervical insemination, or when it is a part of the picture of a spermatoc dysplasia. A low sperm concentration seems to be of special clinical significance only when it drops to a level of about 10,000 per cu. mm., or when the low concentration is associated with a germinal dysplasia, causing a sharp reduction in the ratio of normal gametes.

The fertilizing ability of spermatozoa is more concerned with the quality of the cells, and frequent conceptions may be expected with low sperm concentrations if the cells are of good quality, whereas if the cells are of very inferior quality, a failure of conception may be anticipated regardless of high sperm concentration or high motility.<sup>17</sup> This rule applies whether the examination is from a bottle specimen or from semen mixed with the rather compatible alkaline secretion from the cervix at the time of ovulation. Judging from instances where the female partner has been subjected to needless, expensive and oftentimes hazardous procedures for the correction of sterility when the fault was actually on the male side, it seems very evident that much more progress may be expected when more physicians consider a routine study of spermatoc pathology as a legitimate and essential part of a sterility diagnostic survey.

A considerable fallacy exists in relation to therapy

of pathologic germ plasm, both male and female, for much of this treatment is directed to the rather impossible task of causing fundamentally pathologic germ plasm to produce normal gametes.

#### FEMALE GERM PLASM

Although female germ plasm is apparently often pathologic and, as a result, the product of ovogenesis is likewise abnormal, there is no method for the direct examination of the gamete and thus estimating its health as in the case of the male. It therefore becomes necessary to resort to various indirect criteria for determining its health. With normal ovulation, a sequence of events commonly transpire which if absent suggests a failure of normal ovulation. Thus a definite periodicity usually results in cycles of somewhat constant length and ovulation at a rather fixed period in the cycle. Cyclic irregularities may be transitory or permanent and reflect to varying degrees a fundamental fault of the germ plasm. Associated with the maturation of the follicle and subsequent lutein formation, there are cyclic variations in the elaboration of estrin and progesterone along with the concomitant effects on the genital tube of the female, such as cornification of the vaginal epithelium, deposition of glycogen in the epithelium of the vagina and endometrium, cyclic changes of the endometrium which distinguish the proliferative and secretory phases of the cycle, and cyclic changes such as the basal body temperature. Thus on the one hand, there may be anovulation, a subnormal uterine development, no menses or very infrequent menses, endometrial hypoplasia, subnormal glycogen deposition in the vaginal mucosa, a monomodal basal body temperature curve, and perhaps an interference with the development of the normal secondary sexual attributes and at the other extreme, various attributes, both physical and functional which distinguish the normally developed, fertile woman. Between these extremes, there are wide variations in the degree of ovular and ovarian health. With the recognition of the relationship between ovular development and cyclic variations in basal body temperature, we have been provided with greatly improved means by which faulty ovulation or anovulation may be clinically detected. Any deviation from the normal cyclic temperature pattern is suggestive of an abnormality in the development of the ovum. Such deviations are often associated with evidences of an abnormality in ovarian secretion such as a subnormal endometrial development, but in other instances, how-



ver, marked irregularities of the ovulation phenomenon are associated with normal cyclic changes in the endometrium and the vaginal epithelium. In the realm of diagnosis, basal body temperature records and endometrial biopsies cover a somewhat different ground so that one cannot replace the other. Many cases with basal body temperature evidence of ovular pathology cannot readily be diagnosed, if at all, by other means than the basal body temperature record, and conversely the basal body temperature is quite worthless in the recognition of endometrial pathology.<sup>1,18,19,20</sup>

Several types of temperature patterns may be distinguished and they possess differences in clinical significance.

*Type I*—Normal bimodal curve with the time of the temperature shift varying not more than about two days from the mean ovulation time. Most conception occur with this type (Figure 1).

*Type II*—Monomodal temperature curve of pregnancy, normally at a constant level between 98.5 and 99 degrees F. or slightly higher. In some cases with pre-conception temperature abnormalities, the temperatures of pregnancy are quite variable in height and assume a much lower level than the normal temperatures of pregnancy.

*Type III*—Wide variations in the time of temperature shift or ovulation depression. Endometrial biopsies usually show normal cyclic endometrial changes, but the conception rate seems very low.

*Type IV*—Monomodal cyclic temperature curves with wide temperature variation. The temperature ranges largely above 98 degrees F. in some, and below 98 degrees F. in others. Some of these fall in the group with thyroid deficiency, ovulate under thyroid therapy and conceive. Others, part of whom have a proliferative type endometrium, persist in revealing no basal body evidence of ovulation.

#### RECORD OF BASAL BODY TEMPERATURES

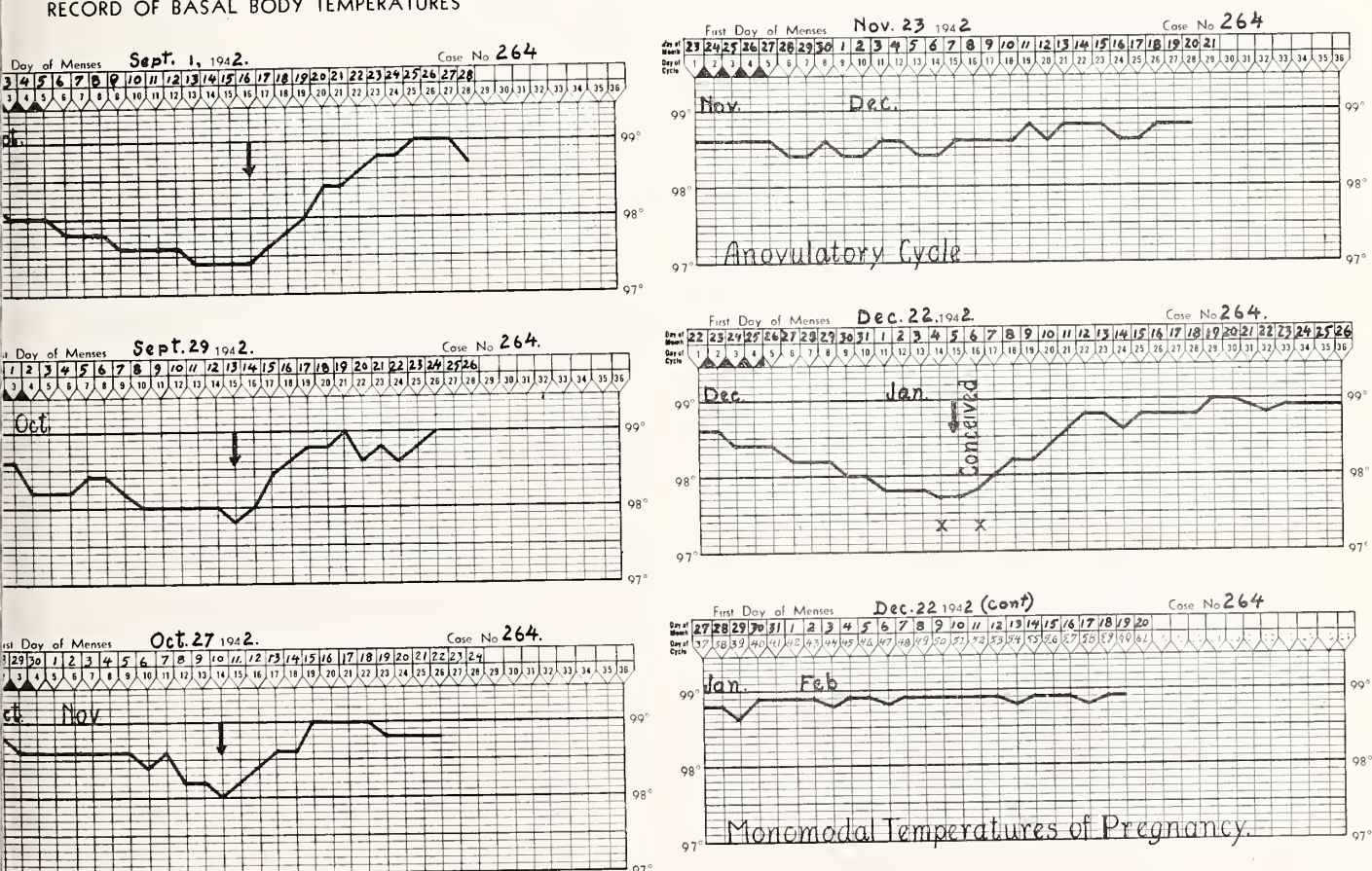


FIGURE 1

Case No. 264. Basal Body Temperature Record of normally ovulating woman. The type of curve varies considerably in different women, but if the given woman should be of a rather constant pattern from month to month. Usually, the time of ovulation does not vary more than about 2 days from the mean ovulation time. The first three cycles shown here are normal, bimodal temperature curves typical of ovulatory cycles. The fourth cycle is anovulatory. The fifth is normal, with conception occurring at the time of the temperature shift, and followed by the sustained, high, constant temperatures typical of pregnancy.



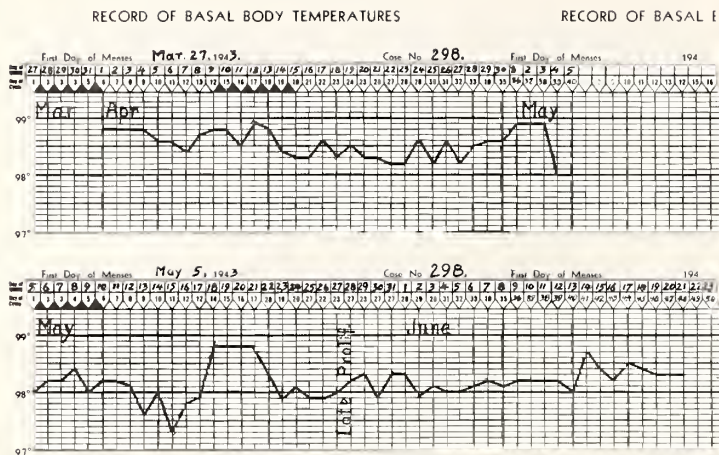


FIGURE II

Case No. 298. Monomodal type temperature curve commonly associated with a proliferative type of endometrium and generally considered anovulatory. Conception uncommon with this type of case. The basal metabolic rate is normal.

tion, and fail to conceive (Figures II and III).

*Type V*—Monomodal curves with constant temperature levels, male type, at about 98 degrees, distinguished from the temperatures of pregnancy by the lower temperature level. Some of these are not persistently monomodal and eventually conceive.

Various combinations of those general types occur in different individuals, but we have not observed a conception without basal body evidence of ovulation at the time of conception. If we are to estimate the normalcy of the follicular apparatus on the basis of its secretory activity, it is quite necessary to employ basal body temperature records or such other objective clinical methods as we may have at our disposal. As far as is known, normal gametogenesis cannot be determined by hormone assay, principally due to variability in normal hormone levels and difference of reactivity of the tissues of different individuals to given levels.<sup>6</sup> There is undoubtedly a very definite optimum for various hormonal levels which are necessary for fertilization and nidation, as indicated by the marked variations in basal body temperatures which typify normal ovulation and fertilization. A study of basal body temperatures and endometrial biopsies seems to furnish the best clinical means for indicating optimal levels.

In clinical cases of infertility, we are rarely concerned with the stigmata of pituitary disease, or are we provided with the facilities which will permit the diagnosis of marginal pituitary disease which

may be present without clinical stigmata. The treatment of surgically induced anterior pituitary deficiency of rats is quite a different problem than the treatment of an unproven anterior pituitary deficiency of woman. The beneficial results of treatment of artificially induced glandular deficiency in rats are not readily transposed to woman when no such deficiency has been proven to exist. It has been a rather common observation that if defective ovulation is associated with a low basal metabolic rate, evidences of ovulation followed by conception will frequently follow adequate thyroid administration (Figure II). Several months of thyroid therapy are often required before any effects upon

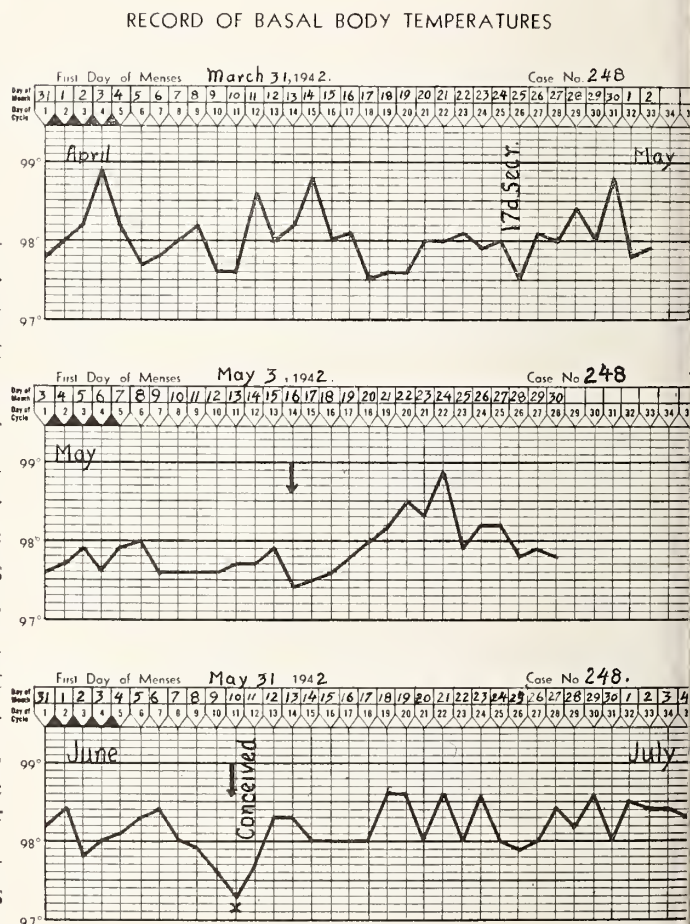


FIGURE III

Case No. 248. Abnormal type of temperature curves associated with a low basal metabolic rate (minus 34 per cent) and a progestin deficiency as indicated by an endometrial biopsy. Conception occurred on the third month of intensive thyroid therapy from a homo-insemination performed on the day of the temperature shift. The high sustained temperature level typical of conception is absent in this case, as frequently happens in association with marked preconceptional basal body temperature irregularities.



ne basal body temperature fluctuations will be noted. Many instances of defective ovulation are very persistent from month to month and are not associated with a low basal metabolic rate. They apparently represent the result of intrinsically pathologic germ plasm equivalent to a germinal dysplasia of the male, and they offer an equally poor prognosis. Much progress seems possible in the endocrine approach to this phase of the sterility problem, but if so, cases will need be studied more intensely from the endocrine aspects and perhaps require better clinical methods of approach. The premise that failure of ovulation or normal ovulation due to a lack of glandular stimulation should be based upon objective clinical studies before it can carry much weight from the diagnostic point of view. Judging from clinical results with the use of gonadotropins in humans, it seems very doubtful whether defective germ plasm of either the male or female has ever been sufficiently benefitted by their use to result in a conception in consequence, although it is quite likely that conceptions occasionally occur in spite of their use when the germ plasm is not highly defective. One might logically employ basal body temperature records and the endometrial biopsies to indicate the effects of the gonadotropic hormones but investigations along these lines have so far been on the negative side.

#### EXAMINATION OF THE GENERATIVE ORGANS

The physical examination of the generative organs occupies a relatively less important position in the realm of diagnosis of male and female sterility than formerly. In the male, one is interested principally in the ability to ejaculate normal semen, containing a normal sperm population. Abnormalities that do not interfere in this respect are usually not important from the viewpoint of male sterility. A lack of testicular development may be very significant because it is so commonly associated with spermatocytogenesis, an epididymal induration, because of the possibility of closure of the epididymal tubules, and tenderness of the prostate is commonly associated with an abnormal content of white blood cells in the seminal fluid, which in some cases seems to reduce sperm viability. Thus, the general examination of the male generative organs occasionally furnishes an important background for a better understanding of the seminal findings and the likelihood of improvement under therapy. Negative physical findings of the male, without a thorough semen

examination are, however, worthless as a basis for estimating the state of fertility.

The diagnostic value of a routine pelvic examination of the female has been and still is much overrated as a means of estimating fertility, both from the viewpoint of interpretation of abnormal findings, and the clinical significance of negative findings. When abnormalities of the female tract are disclosed, one should consider in their evaluation whether they are of such a nature as to interfere with the reception and upward migration of the spermatozoa, with the descent of the ovum or with the nidation and growth of the fertilized ovum. Perhaps, the presence of cysts in the ovaries may interfere with the maturation of the ovum and ovulation. Supplementary examinations such as an endometrial biopsy and basal body temperatures should answer these questions. The vaginal examination should reveal any abnormality of secretions, an abnormal discharge or pathology of the cervix that might interfere with sperm migration. A post-coital test at the period of ovulation will reveal whether cervical insemination and the upward migration of the spermatozoa is occurring. If normal, it is common to be able to recover motile spermia from the uterine cavity, as well as from the cervical canal within five to fifteen hours after coitus.

Cervical insemination with highly healthy sperm populations, commonly results in a higher concentration of motile spermatozoa in the mucus obtained from high in the cervical canal by means of suction than exists at the external os where the mucus is exposed to the acidity of the vagina. If the tests are conducted within the first hour or two after cervical insemination, positive tests will be obtained in most cases, irrespective of the health of the sperm populations, or the condition of the female.

In the past, and still yet to a certain extent, an unwarranted emphasis has been placed on abnormalities of uterine position in relation to the production of sterility. Only too frequently, no adequate examinations of either the male or female are made prior to fixation operations, and since it has not been determined whether normal spermia have been gaining entrance into the uterus, whether the tubes are patent or if the endometrium is normal, much needless surgery results. Usually, an abnormality of uterine position is of no consequence from the viewpoint of infertility unless associated with infection or adhesions or unless its position produces some

objective or subjective evidence of altered function.

Likewise, small retention cysts of the ovaries have been the cause of much needless surgery, often of a mutilating character. It seems wise that the treatment of such cysts should be from the endocrine approach, employing such tests as basal body temperatures, endometrial biopsies, and hormone assays to estimate the degrees to which ovulation has been impaired and as a guide to therapy. The removal of ovarian tissue is a questionable answer to this type of pathology. Some believe that small doses of x-ray give the best therapeutic results in this type of case, but clinically, the diagnostic criteria are often not sufficiently established to permit any evaluation of the results. On theoretic grounds, it seems plausible that some of the cases should be benefitted if the estrogens production were thereby slightly diminished, and the ova not injured.

In the production of sterility, there seems little question of the significance of an infantile uterus, yet the mere smallness in size of the uterus is not necessarily inimical to conception. Other signs of immaturity should be present, such as an hypoplastic endometrium, an abnormally large ratio of the length of the cervix uteri in relation to that of the fundus and perhaps somatic stigmata of sexual immaturity. Obviously, then, a pelvic examination in itself is often very inadequate to justify the diagnosis of an infantile uterus and one must be aided by such procedures as determining the uterine index with the aid of a hysterometer and from endometrial biopsy.

For a great many years, disease of the Fallopian tubes has been recognized as the most frequent cause of female sterility, and although a history of gonorrheal infection or any pelvic inflammatory disease, or the finding of any pelvic induration, suggests the presence of tubal pathology, the study of the Fallopian tubes by means of gas insufflation or by salpingography is necessary for any valid diagnosis as to tubal patency and normal function. In consequence, it is quite natural that uterotubal insufflations should have become the most frequently conducted tests used in the diagnosis of sterility, particularly inasmuch as most sterility work has fallen the responsibility of gynecologists. In practice, however, the test has led to various abuses, first because too many doctors have limited their diagnostic acumen too greatly to this single test, neglecting other phases of sterility diagnosis, and secondly, because of the employment of faulty technique in

conducting the test which has too frequently led to false interpretations and unnecessary hazards to the patient. The Rubin Test, or utero-tubal insufflation, hypothecates the use of carbon dioxide gas, with facilities for controlling the rate of flow, the pressure and the volume of gas used. No more gas than necessary for determining tubal patency should be used. Usually 30 to 50 cc. of gas suffices for a test. If the test is done according to the technique recommended by Rubin, the results are highly informative and the hazard to the patient is minimal. Diversification from the recommended technique,<sup>21</sup> such as the use of other than carbon dioxide gas, uncontrolled volume, pressure or rate of flow, the conducting of the test too close to menses, too soon after parturition, in the presence of pregnancy, or in the presence of an active infection, all provide hazards to the patient which in the light of common accepted medical practices and standards, provide indefensible medical legal liabilities. Unless one is equipped to run this test as it is supposed to be run and provide the patient with the ordinary safeguards, it is best that the test should not be attempted.

Considerable controversy has been waged over the relative merits of tubal insufflation versus salpingography. It seems very evident that both procedures are fundamentally safe, and carry with them no significant hazard to the patient if they are conducted properly. The objection raised against the use of an opaque medium is that its presence in the pelvic cavity may set up a foreign body reaction and cause the sealing of otherwise patent tubes. Again in insufflations, the objection raised is that it does not provide as much information as gained by uterine salpingography, that the actual point of tubal closure cannot be determined as a prelude to surgery, and further that the injection of fluid medium provides a better means than gas for the mechanical opening of partially occluded tubes. It seems very evident that each of these methods has its place in the diagnostic agenda. If the tubes are normally patent, insufflation will give this information just as well as an opaque medium, and without the possible hazard of foreign body reaction, and certainly, closure or partial closure of the tubes usually can be diagnosed as readily with gas as with an opaque medium. On the other hand, the x-ray provides a means of determining the point of obstruction, a type of information which is valuable if surgery is contemplated for tubal obstruction. Thus it has become



the practice by many to use carbon dioxide insufflation as routine in all cases, and then if an obstruction is encountered, to study the case further by means of salpingography. If the use of the contrast medium is limited to those with tubal obstruction as determined by a tubal insufflation, the contrast medium will gain entrance into the pelvic cavity in a very limited amount and in a very small ratio of the cases handled. One of the more readily absorbable contrast media such as Iodochloral is generally recommended so that a permanent residue is not left in the pelvic cavity. In case of the use of either gas insufflation or salpingography there is some evidence that closure of the tubes may be better overcome if the test is preceded by a course of testosterone to cause tubal growth, and by the use of atropine just before the test to overcome tubal spasm.

In well balanced studies, there is no particular reason why the desirable features of tubal insufflation and salpingography should not fit into the diagnostic requirements. Carbon dioxide insufflations are conducted so much more cheaply and quickly that there is little question of the method of choice for the mass of cases without some special diagnostic requirement. It seems that the injection of a fluid medium will dilate some tubes which fail to dilate with gas pressure, but the difference in dilating effect is not great, and is denied by many, including Rubin. When performing a utero-salpingography the same safeguards as used with insufflations should apply, including the injection of the contrast medium under controlled pressure, limited to 200 mm. Hg.

The combination of tubal insufflation, pneumoperitoneum and utero-salpingography offers the advantage of visualization of the pelvic viscera, including the uterus, Fallopian tubes and ovaries, thus permitting the recognition of various types of pathology which would otherwise have to await laparotomy.<sup>22</sup>

#### SUMMARY

It has here been attempted to review some of the more important features of the sterility diagnostic program concerning male and female sterility. It is desirable that those interested in this study so equip themselves that a comprehensive study of both partners will be possible. As in other branches of medicine, a diagnosis of the fundamental disorder is necessary for an adequate diagnosis and therapy, but different than other branches of medicine, the diag-

nosis and prognosis usually involves the comprehensive consideration of two persons, rather than one. The responsibility for this dual study must fall upon a single doctor, although in many instances group studies are a great asset. The greatest criticisms of many sterility investigations as generally conducted today are that they (1) too frequently involve a single partner, (2) that the studies of this single partner are too limited in scope, (3) that an attempt to round out various phases of the study by referring the patient to other doctors often falls short of the desired diagnostic requirements because of the lack of interest or equipment required for the study, and (4) that too long a period of time commonly elapses in making the basic examinations of the diagnostic survey.

When comprehensive examinations are made, a definite prognosis will be justified in a much larger proportion of the cases than in the past. In the writer's experience, about 25 per cent of the couples whose infertility is of over two years' duration will present types of pathology which should be considered as incurable impediments to reproduction. With these, a hopeless prognosis should be given just as soon as the necessary diagnostic studies have been completed. It is important that the diagnostic program should be arranged so that the necessary information on both partners be promptly accumulated, and the indicated case management instituted at once. When one encounters case after case with diagnostic studies of an abbreviated nature and with which various types of therapy have been carried on over a period of years without any comprehensive basic studies having ever been completed on either partner, the desirability of a promptly conducted comprehensive study becomes very apparent. If the male is considered potentially fertile, arrangements should at once be made to proceed with the examination of the female. If the husband should be found hopelessly sterile, the couple is so advised at once, so that they may choose of the obvious alternatives, (1) artificial insemination with semen from a foreign donor, provided that tests indicate that the wife is fertile, (2) adoption, or (3) cessation of further efforts or thought of having a family.

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## CONTROVERSIAL ASPECTS OF THE SURGICAL TREATMENT OF PEPTIC ULCER

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CURRENTLY three controversial aspects of the surgical treatment of peptic ulcer disease are importantly engaging the attention of both clinical and experimental groups in medicine and surgery. Of these three, the question of whether a given *gastric ulceration* is benign or malignant takes first place in importance since improper management of the patient within this group is one of the saddest stories in the delayed treatment of gastric cancer. Secondly, the mortality from *massive ulcer hemorrhage* has been demonstrated to be sufficiently great to invite a trial of immediate surgical intervention in selected instances at least, to determine whether or not this mortality can be reduced. Thirdly, the recurring question of the best surgical pro-

cedure for the treatment of duodenal ulcer has been given new life by the introduction of the operation of *vagus nerve resection*.

### GASTRIC ULCER AND GASTRIC CANCER

That an important number of gastric ulcers which appear benign roentgenologically, are found to be malignant in patients whose symptoms and other findings do not contribute to a more satisfactory diagnosis is fairly well established. Allen and Welch demonstrated a cancer incidence of 14 per cent in a group of patients whose original working diagnosis had been benign ulcer. Since the ulcer cancer type is one of the more curable forms of gastric cancer, early operation, without delay is most desirable.

*Presented at a meeting of the New London County Medical Society 3 April 1947*

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Wrong diagnosis with months of futile medical treatment can only imperil the patient's life. So important is early surgery that today in many quarters there is a general tendency to advise surgery without a trial of medical treatment when a gastric ulcer is found. This concept does not apply at all, of course, to duodenal ulcer which is always a benign lesion. The aids in differential diagnosis between benign and malignant ulcer are well known. Absence of free hydrochloric acid, large ulcerations, ulcerations on the greater curvature of the stomach, pyloric lesions, and ulcers of short duration in the older age group patients are particularly indicative of malignant lesions. On the other hand, no region of the stomach or train of circumstances exempts a gastric lesion from suspicion. Expert roentgenologic assistance and gastroscopic observation further aid in diagnosis, but, in the end, the somewhat hazardous trial of medical therapy and observation must be relied upon if surgery is not undertaken.

The confusing picture in the differential diagnosis of benign and malignant gastric ulcer is best illustrated by the following cases observed in the Joseph I. Pratt Diagnostic Hospital. In this institution, no treatment is carried out, advice is given in consultation, and follow-up data obtained.

CASE I—M. R. VERY LARGE BENIGN ULCER

A 48 year old very obese man was first seen at the J. H. Pratt Diagnostic Hospital in July of 1945. At that time he gave a dyspeptic history of five years' duration. An enormous crater high on the lesser curvature was found on roentgenologic examination which may be seen in Figure 1. Total acidity measured 68 cc. of N/10 NaOH and the figure for free hydrochloric acid was 52. A course of strict medical treatment for four weeks was advised after a diagnosis of probable benign ulcer had been made. This patient has returned repeatedly to the hospital for roentgenologic and gastroscopic examination and no surgery has been undertaken for various reasons. His last admission was in March of 1947. At no time has this ulcer been completely healed although he has had relief of symptoms.

This patient demonstrates several items of interest. First the size of this ulceration makes it suspect of malignancy but the clinical findings and course are those of a benign ulceration; secondly, the difficulty of healing gastric ulcers is demonstrated; thirdly, relief of symptoms is not an indication of healing.

CASE II—H. M. MALIGNANT ULCER WITH ALL APPEARANCES OF A BENIGN LESION

A 38 year old man was admitted to the J. H. Pratt Diagnostic Hospital in November 1939 with a dyspeptic history of 5 years duration. Two previous roentgenologic examinations of the stomach had been negative elsewhere. A gastric ulcer on the lesser curvature of the stomach at the angulus was found (Figure 2). This ulceration had all the charac-



FIGURE 1

Very large ulcer crater high on the lesser curvature of the stomach with incomplete healing over a period of almost two years (Case I)

teristics of a benign lesion roentgenologically and gastroscopically. There was no free hydrochloric acid present in the fasting stomach and only 12 units after histamine stimulation. Surgery was advised by several consultants but a compromise of three weeks medical trial first was settled upon and carried out in other hands. This apparently relieved this patient's symptoms and surgery was not undertaken. Readmission for diagnosis was not carried out as advised. Seven years later this patient was operated upon and a carcinomatous ulcer found. No metastases were present.

This case demonstrates the following points: (1) typically benign gastric ulcers, roentgenologically and gastroscopically, may be malignant; (2) relief of dyspepsia by trial medical treatment may defeat attempts at reexamination; (3) absence or very low free hydrochloric acid in the stomach is an aid in diagnosis. The seven years duration of this lesion brings up the question of cancer arising in a benign ulcer. In general, however, pathologists believe that malignant transformation does not occur and such cases are considered evidence of slow-growing cancer.

CASE III—I. L. GASTRIC ULCER WITH OTHER ROENTGENOLOGIC EVIDENCE SUGGESTING CANCER ON SECOND EXAMINATION

In Figure 3 repeat roentgenograms taken in the case of a 61 year old man disclosed an ulceration in the body of the stomach with a surrounding area of infiltration suggesting a malignancy. Dyspeptic history was of one year's duration. Total acidity measured 22 units with 10 units of free hydrochloric acid. At the first roentgenographic examination, the stomach adjacent to the ulcer could not be properly examined. A second examination revealed the na-





FIGURE 2

Gastric ulcer on the lesser curvature at the angulus with all the roentgenological appearance of a benign lesion. At operation seven years after this roentgenogram a malignant ulcer was found in the same area (Case II)



FIGURE 3

Roentgenograms in this case show stiffening and rigidity of the gastric wall adjacent to the ulceration on the lesser curvature indicative of carcinoma which this proved to be on resection (Case III)

ture of the lesion. Gastric resection was performed and the diagnosis of gastric cancer confirmed.

In this instance we may observe that low values for free hydrochloric acid are significant in the diagnosis of gastric cancer. In addition, the importance of a repeated roentgenographic study in doubtful or difficult cases is borne out.

#### CASE IV—M. G. BENIGN PREPYLORIC LESION RESEMBLING GASTRIC CANCER ROENTGENOLOGICALLY

In Figure 4 the roentgenographic appearance of the prepyloric lesion with small ulceration and considerable surrounding infiltration indicated the diagnosis of gastric cancer. This 59 year old woman had only a 30 day dyspeptic history. Gastric resection was performed and a benign ulcer with no evidence of gastric cancer was reported by the pathologist.

This case represents evidence of the difficulties in diagnosis. There was, however, an episode of hematemesis and melena associated with the illness which might point somewhat to a benign lesion. In any event this sort of lesion demands surgical intervention for diagnosis.

#### CASE V—W. B.

In Figure 5 roentgenograms of a gastric ulcer taken in the case of a male patient aged 53 may be seen. The patient had a history of one month's duration of dyspepsia. The value for total acidity measured 110 units with free acidity of 90 units. The diagnosis of benign gastric ulcer was made. After a month of strict medical treatment, however, no diminution in the size of the ulcer was observed and gastri-



FIGURE 4

A pre-pyloric benign ulceration with considerable infiltration of the surrounding tissue. The lesion resembles carcinoma roentgenologically but at resection no evidence of cancer was found (Case IV)



resection was carried out. At operation the lesion proved to be benign. This case illustrates the difficulty in healing gastric ulcers which, in many instances, is indication for operation itself whether or not one suspects the lesion of being benign.



FIGURE 5

Roentgenograms of a benign gastric ulcer which showed no healing after a month of medical treatment (Case V)

The histories of the patients described above indicate the complexity of the gastric ulcer diagnosis problem. The danger of gastric ulcer cancer has influenced some surgeons to recommend surgery as the most certain diagnostic procedure when a gastric ulcer is found. On the other hand, there is a large number of patients in whom the diagnosis of a benign lesion has been substantiated by their subsequent course and who have avoided operative risk. What course to follow in patients with gastric ulcer is debatable but at the present time a trial of medical therapy in the majority of gastric ulcer patients is not unreasonable, provided conditions are ideal for therapy and diagnosis.

A plan which I have used in most instances is as follows:

1. Patients with gastric ulcer should be seen by

the surgeon as well as the physician when the diagnosis is first made.

2. A general appraisal of each case should be made and if the evidence is at all in favor of a malignant lesion, early surgery should be advised. Particular value in differential diagnosis is placed on the following items in the approximate order of their importance—(a) the clinical history, (b) the location of the ulcer, (c) the size of the ulcer, (d) gastroscopy, and (e) absence of free hydrochloric acid. Other factors are similarly recorded and a judgment made. If it be decided the patient has in all probability a benign ulcer, this lesion is still held suspect until complete healing has been obtained.

In carrying out such a program there are important stipulations to be made. The services of an expert roentgenologist are required. Many patients with wrong diagnosis of benign gastric ulcer are found to have changes adjacent to the ulcer which to the expert fluoroscopic examiner are sufficient indication for a positive diagnosis of gastric cancer. Gastroscopic examination is particularly useful and even necessary in doubtful cases and, in the follow-up of the healing process under therapy, offers a more satisfying technique than roentgenologic methods. A third requisite of medical therapy trial is *good medical therapy*. Patients under diagnostic trial must be in bed and the strictest of Sippy regimens followed. Adequate alkaline therapy is essential, and for this treatment, absorbable alkaline powders are recommended. All too often diagnostic medical therapy is haphazard and the relief of clinical symptoms used as a measure of diminishing dietary and alkaline therapy. It must be kept in mind that the aim of treatment is an anatomically perfectly healed ulcer and that the absence of dyspepsia is not a sign of healing. Repeat examination should be carried out in three weeks and progress noted. Complete healing ideally should be accomplished in four to six weeks as far as the roentgenologic evidence is concerned. Gastric ulcer cancers do not heal completely although one must beware of two pitfalls in this regard: symptomatic relief may be obtained by medical treatment and some diminution in the ulcer crater may be observed.

The program further includes a recourse to surgery at any stage of the treatment. Following such a careful program, in patients who by all criteria have a benign ulcer, will result in at most a few weeks delay in a very small group who ultimately prove to have cancer at operation. The incidence of

cancer in 869 gastric ulcers of 2.5 cm. in diameter or under has been reported to be 14.5 per cent by MacCarty.<sup>2</sup> Since these figures are those for resected specimens, the incidence of carcinoma in the same size ulcers which have no other evidence for the diagnosis of malignancy is probably considerably less.

If doubt exists at any time, operative interference is the best choice. We have much more frequently operated on patients with doubtful ulcers which proved to be benign than we have on those with ulcers previously classified as undoubtedly benign where malignancies were discovered. When all of these valuable techniques and assistants are not available, a more active program of surgical interference must be carried out.

#### IMMEDIATE SURGERY FOR ULCER HEMORRHAGE

Among the first to point out the seriousness of massive hemorrhage of ulcer origin and particularly to emphasize the importance of the age factor in causing death were Allen and Benedict.<sup>3</sup> During the past ten or twelve years, the treatment of patients with massive hemorrhage by feeding has been introduced by Meulengracht,<sup>4</sup> and the operative treatment of severe gastric hemorrhage advocated by Finsterer<sup>5</sup> has been employed to a limited extent. That the Meulengracht method of treatment of gastric hemorrhage or its modifications has offered anything new or valuable in the field of treatment is most doubtful. On the other hand, that surgical interference in certain cases during acute hemorrhage has lowered the general mortality has not been shown conclusively. Our own study of this problem at the Albany Hospital<sup>6</sup> has pointed out the problem and defined the field for surgical trial. We found that the mortality rate among 125 patients with massive hemorrhage of ulcer origin was 8.8 per cent. Other investigators have found this rate even higher. Under 50 years of age the mortality rate was 1.3 per cent and over 50 years it rose to 20 per cent (Figure 6). Obviously the field for surgical endeavor lies in the older age group and in these the reason for continued hemorrhage and death can be attributed to the local vascular changes accompanying advanced age. The inelasticity of medium-sized arterioles maintains the patency of vascular erosions. Under such circumstances, the procedure to be recommended in the management of ulcer hemorrhage is again a combined attendance of the physician and surgeon and a separate judgment must be made for each patient. The pursuit of a course of

non operative treatment in all hemorrhage patients is not reasonable in institutions prepared to handle these serious problems. It is clear that surgical intervention in the very old patient with cardiovascular disease or in the patient who has been bleeding for a long period of time and is extremely depleted will offer a prohibitive risk for surgery. Yet there is definite group in whom surgery can be withstood probably at a risk less than that for the unoperated group.

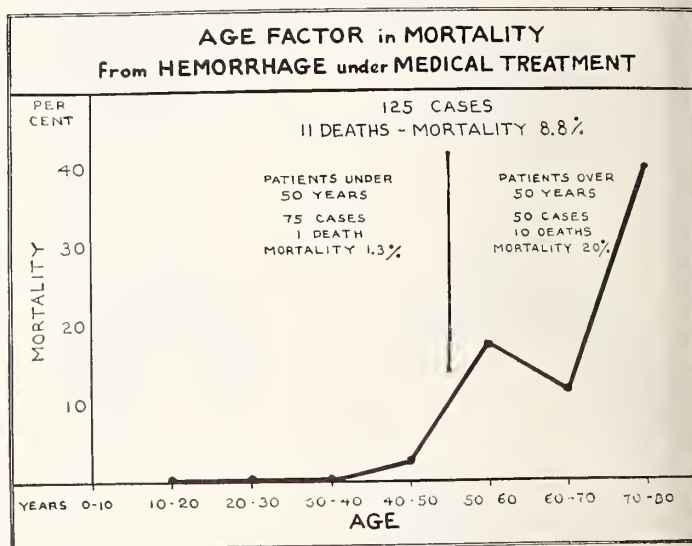


FIGURE 6

Careful selection of patients for surgery, therefore, may reduce the overall mortality from gastric hemorrhage, and hemorrhage must be considered a combined medical and surgical problem. Entering the picture of surgery for ulcer hemorrhage are, however, two important complications. Massive gastrointestinal bleeding may not be of ulcer origin in which event surgery is usually best not undertaken. In addition, from the technical standpoint, the operator must contemplate a gastric resection as the only sure means of hemorrhage control, which is a time consuming operation requiring considerable experience to execute with dispatch. If circumstances for reasonable diagnosis and for adequate operative treatment are not at hand, the best course to pursue is the old method of non interference, sedation starvation with the employment of blood transfusions for the control of shock and severe anaemia.

#### SELECTION OF OPERATIVE PROCEDURE

No one has said that an ideal operation has been found for the treatment of duodenal ulcer. Until the etiology of the disease is more thoroughly understood, we must be content with surgical measure



which eliminate the ulcer in so far as that is possible and reduce gastric acidity. Up until recently when vagus nerve resection for the control of ulcer was introduced, patients who had been operated upon for duodenal ulcer had had performed one of three types of operation, pyloroplasty, posterior gastroenterostomy or partial gastric resection. The operation of pyloroplasty has become practically historical, very few having been purposely performed during the last ten years. Posterior gastroenterostomy has lost its previous great favor because of the high incidence of jejunal ulceration, necessitating secondary operation. Partial gastric resection has been the operation of choice and has given excellent results with a low incidence of subsequent jejunal ulceration. The partial or complete success of each of these operations has its basis in the effective reduction in gastric acidity accomplished. In the case of pyloroplasty, the reduction in gastric acidity is accomplished by the reflux of duodenal fluid into the stomach after the pyloric sphincter has been cut. Gastroenterostomy results in the regurgitation of intestinal fluid into the stomach and an even more effective acid reduction than pyloroplasty. When partial gastric resection is performed in addition to the duodenal regurgitation factor in acid reduction, two other mechanisms further effect a reduction in the amount of hydrochloric acid secreted by the gastric cells. These are the removal of some acid-secreting mucosa, and pylorotomy. The pyloric antral mucosa apparently elaborates an internal secretion which stimulates acid secretion by the gastric cells and its removal reduces such acid secretion. Studies<sup>7</sup> on a group of postoperative patients using an acid test meal have shown that pyloroplasty results in approximately a 25 per cent gastric acidity reduction and gastroenterostomy, a 50 per cent reduction under the best of conditions. Both of these reductions are insufficient to control ulcerations and to prevent new jejunal ulceration. Studies in gastrectomized patients show complete reduction in the same time period. This data has its corollary in the clinical results. It accounts for the success of partial gastrectomy in patients. It further illustrates that an attack on acid secretion is a sound working rule in ulcer control by surgery, as it has been in the medical treatment.

Considering the fact that partial gastrectomy is found to be so satisfactory in the control of ulcer and that it fulfills the important requirement of great acidity reduction, I am reluctant to accept vagus nerve resection as an adequate substitute for this

operation. The effectiveness of vagus nerve interruption has also as its basis reduction in gastric acidity. But the reported effective reduction after vagotomy does not approach that of gastric resection. The experimental basis for the operation was established by Hartzell<sup>8</sup> in 1929 when he demonstrated that section of the vagi reduced gastric acidity in dogs. Studies of some of these same animals done later by Vanzant<sup>9</sup> indicated a return of the acid secretion to normal. This later experimental study would not seem to offer much hope for the permanence of acidity reduction by vagus nerve resection, an essential feature of a successful operation for ulcer control.

Trial of various types of vagus nerve resections were reported in 1930 by Italian surgeons<sup>10</sup> but large scale use of the operation in peptic ulcer patients has only recently been undertaken in this country, notably by Dagstedt<sup>11</sup> and Moore<sup>12</sup> et al. These experimental trials of vagotomy will be followed with interest. At the moment, however, insufficient time has elapsed for any of these reports to establish conclusively the value of this operation. Careful studies of controlled groups of patients should be continued by such groups, but the widespread use of this operation before it has been established on firm ground should be condemned. It may be that vagotomy will find its role of usefulness in selected groups of patients; already definite contraindications to the operation have been established.

#### MORTALITY IN GASTRIC SURGERY

One of the most important aspects of surgery for benign lesions is a careful consideration of the risk which such patients incur by electing operation. The physician attending a patient with a gastric ulcer that may or may not be malignant is rightly concerned with operative mortality. In a series of 102 gastric operations for ulcer our mortality rate has been 3.9 per cent for all operations, and 1.4 per cent for sub-total gastric resection.

#### GASTRIC AND DUODENAL ULCER

OPERATION	NUMBER	MORTALITY	
		DIED	RATE
Partial gastric resection .....	72	1	1.4%
Gastric resection for jejunal ulcer and gastrojejunal fistula .....	6	2	
Gastroenterostomy and pyloroplasty .....	24	1	
Total .....	102	4	3.9%

The risk for uncomplicated gastric resection is therefore under 2 per cent, a reasonable figure for the patient with benign gastric ulcer. For those who face the risk of repeated hemorrhage and its higher mortality with advancing age, the election of operation after a bout of hemorrhage would seem to be the wise course. The mortality from operation during hemorrhage has been reported by Finsterer as 5 per cent. The ages of his patients, however, have not been reported. If we confine our attempts to reduce the mortality from hemorrhage by surgery in the older age patient, the mortality figure will undoubtedly be higher than Finsterer's. Such trials are justified by the mortality rates in the unoperated group. The mortality rate for vagus nerve resection has not been established in a large series, but it is doubtful that this operation can be done at a much lower figure than that for primary subtotal gastric resection. This issue alone, however, is not the important one in the selection of operation.

Pyloroplasty and gastroenterostomy should probably not be done except under unusual circumstances since secondary operation with a higher mortality may be necessary later.

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## POLYPOID CECAL MASSES PRODUCED BY INVAGINATED APPENDICEAL STUMPS

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**F**OLLOWING appendectomy, a number of deformities of the cecum may be observed. There may be postoperative alterations associated with irregular narrowing of the cecal lumen. Occasionally, there is inversion or protrusion of the appendiceal stump with varied deformity of the cecal base. The cecum may show serrations or only slight changes in its contour or it may be invaginated and fixed by surrounding ileocecal adhesions. The formation of an intraluminal cyst by the invaginated appendiceal stump forming a polypoid mass in the cecal base has been noted. Artner<sup>1</sup> has described various changes involving the cecum in the region of the

appendiceal stump in 33 per cent of 400 cases examined. In 8 per cent of cases, peculiar ring shadows were noted. This investigator ascribed the change to the use of the circular sutures with the invagination of the appendiceal stump. The resultant ring formation and the subsequent use of transverse sutures may produce the irregular contours of the cecum so often noted during the roentgenographic examination of the large bowel. Occasionally, the roentgenographic studies may demonstrate a small rounded or ovoid mass in the cecal tip. The inverted appendiceal stump may produce a persistent bulbous mass protruding into the cecal lumen.

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Artner and Weber and Good<sup>2</sup> have noted that the invaginated appendiceal stump may be demonstrated as a small rounded intraluminal filling defect in the cecal tip. The rounded filling defect in the base of the vermiform appendix can be very satisfactorily shown by compression of the barium-distended cecum. Very often the rounded mass (Figure 1) is well demonstrated in the evacuation films and the alteration in the mucosal pattern is best visualized in this view (Figure 2). In the barium-filled cecum, the bulbous mass produces a smooth rounded defect of decreased density. In the double contrast study, the rounded density outlined by the air simulates a polyp in the cecal tip.

As Weber and Good have stressed, the best demonstration of such defects is obtained by the double contrast study. Distension of the colon by air introduced under roentgenographic control and manipulation of the cecum at this time is recommended. While stereoscopic studies made utilizing the Potter-Bucky diaphragm have been recommended, it is our custom to employ the compression spot device. In this manner, radiographs of the cecum in various positions and with various degrees of compression can be made. Of even greater importance is the necessity of repeated studies in order to definitely confirm the constancy of the roentgenographic findings.

Although the cecal segment containing such a filling defect can be satisfactorily manipulated during the roentgenographic examination, because of its small size, the mass is usually not palpable. The repeated demonstrations of a persistent defect on the medial aspect of the cecum in a patient who had had an appendectomy should make a polypoid invaginated stump a serious consideration.

Clinically, the symptoms associated with such cecal masses have varied greatly. In some cases, the demonstration of such a small but well defined defect roentgenographically has been an accidental finding. On the other hand, instances have been noted where patients have complained of symptoms such as occasional vomiting and intermittent diarrhea associated with abdominal pain and distension. In three of the four cases which we have seen, the patients complained of mild cramps and varying degrees of abdominal pain. In many ways, the symptoms described resemble the condition described by McCann which he has termed the "omental adhesions syndrome." These patients give a history of one or more abdominal operations and have delayed

small intestinal motility. This group of patients complained of chronic persistent postprandial distress, nausea, vomiting and constipation. The pain in the right lower quadrant may often be severe. In the following case, the symptoms have been suggestive of a low grade intermittent obstruction produced by recurrent intussusception.

The report of an illustrative case: JPF. This patient, a 47 year old male was first seen in the Grace Hospital complaining of alternating diarrhea and constipation associated with pain in the lower abdomen. Prior to his entry into the hospital, he had noted that his stools had been reduced in diameter and eight months prior to admission into the hospital, he had noted some pain in the rectum following defecation. Appendectomy had been performed eight years previously.

The physical examination revealed tenderness in the lower abdomen. No localized tenderness in the right lower quadrant could be elicited. Other than a midline and an abdominal scar in the right lower quadrant, no positive physical findings could be elicited. Proctoscopic examination revealed hemorrhoids but no other abnormal findings. The roentgen examination demonstrated a polypoid lesion 3 cm in diameter in the cecal base. At operation, a polypoid mass in the region of the cecum was demonstrated. The pathologic examination demonstrated a rubbery projection of mucosa arising in the site of the previously removed appendix which projected into the lumen of the bowel for approximately 2.8 cm. The mass showed a hemorrhagic tip. It was considered as an inflammatory submucous mass arising from the inverted appendiceal stump.

In each of the three other cases, a similar small polypoid deformity was found in the cecal base following roentgenographic studies. Previous appendectomy had been performed in each case. In one case, operation was refused. In some of the cases seen at the Mayo Clinic, it was believed that the symptoms did not warrant such an operative procedure. Subsequent and serial roentgenographic studies of these patients, however, have been advised.

There are no absolute criteria which will satisfactorily differentiate between the polypoid intraluminal defects produced by a persistent invaginated appendiceal stump and that produced by a polypoid cecal neoplasm. Small polypoid neoplastic lesions can and do produce similar roentgen defects in this area. Roentgen and clinical differentiations between these lesions will be difficult, and in many cases impos-





FIGURE 1

Roentgenogram of the colon by means of the double contrast study method in Case I; the polypoid mass in the cecum at A was subsequently proved at operation to be an invaginated stump



FIGURE 2

Roentgenogram of the barium-filled colon (spot compression film) demonstrates the translucent circular defect in the region of the cecum (Case I)



FIGURE 3

Case III (G. K.) Spot compression film made of the barium-filled cecum demonstrates the polypoid mass in the cecum representing the invaginated appendiceal stump

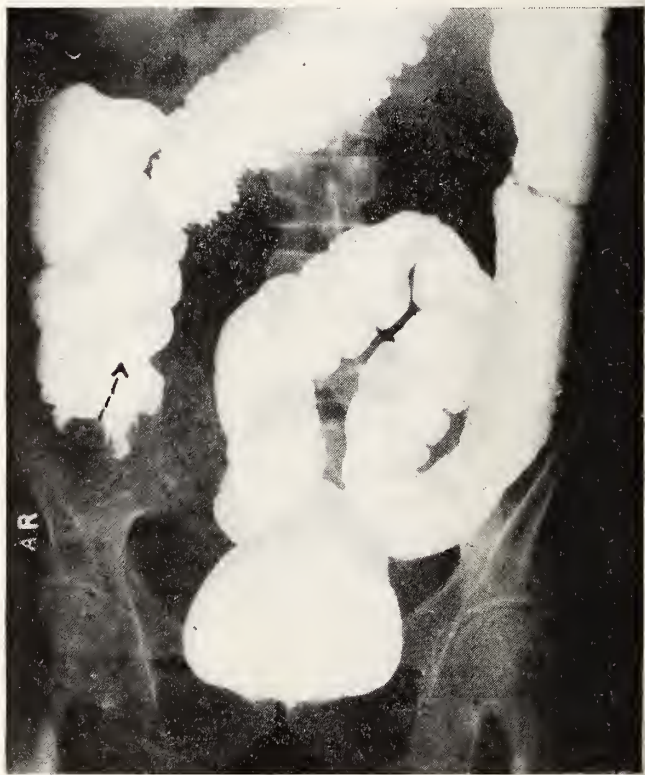


FIGURE 4

(L. H.) This cecal mass (A) was proved at operation to be an adenoma. Note the similarity to the previously described cases



sible. Since malignant polypoid lesions of this area had been demonstrated, surgical removal and a careful detailed microscopic study should be advised whenever any doubt concerning the identity of the lesion exists.

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## HEPATO-BILIARY INFECTION FOLLOWING ADMINISTRATION OF PRIODAX

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IN REVIEWING the literature one fails to find mention of any more serious effects from the use of Priodax than those mentioned by the manufacturer in the leaflet accompanying the tablets. These consist of slight burning sensation in the throat, mild nausea, griping and diarrhea, and occasional transient dysuria. The only contra-indications to the use of the drug are the presence of acute abdominal symptoms, vomiting which would prevent retention of the tablets, acute nephritis and uremia.

Priodax contains 51.5 per cent iodine bound in a stable organic molecule, and is used for radiographic visualization of the gallbladder. It is administered one hour after the evening meal, and nothing is taken by mouth thereafter. The usual, average, adult dose is six tablets of one half gram each, or three grams. This amount is said to be harmless if repeated anywhere from six to twenty-four hours. X-rays are taken twelve to fifteen hours after ingestion of the dye. Following this, a fatty meal is taken and more films are obtained after one hour.

The following case report is submitted as an example of possible reaction to Priodax:

A forty year old white male was admitted to the hospital on March 7, 1947 complaining of cough, dyspnea, chills and fever. He had suffered with a mild upper respiratory infection for about two weeks, until twenty-four hours prior to admission when he became severely ill. His family physician advised hospitalization for "pneumonia." His past history was uneventful, aside from an appendectomy and a herniorrhaphy.

On examination this patient was found to have a rectal

temperature of 104.8, pulse of 120 per minute, respirations 28 and blood pressure of 122 over 70. The only positive findings were over the right upper chest where marked diminution in breath sounds was observed. The white blood count was 22,400 with 84 polys and a chest film showed consolidation of the right upper lobe. Intramuscular penicillin therapy was instituted and in forty-eight hours the patient was afebrile and well on the road to recovery. On the fifth and sixth days of his illness he had afternoon temperatures of 101. The physical examination was normal, and, as repeat x-ray of the chest showed almost complete resolution of the pneumonic process, penicillin therapy was discontinued. This resulted in a prompt drop of the temperature to normal.

On the thirteenth of March, six days after admission, the patient complained of slight discomfort in the right upper quadrant of the abdomen. At this time we were able to elicit this further history, that, for the past year he had had frequent mild attacks of right upper quadrant pain after meals; the pain would radiate around to his back; the attacks were never severe or protracted enough to necessitate his calling a physician. Examination of the abdomen failed to reveal any abnormalities but, in view of the history, it was decided to do x-ray studies of this man's gallbladder.

At 7:00 P. M. of March 16, the patient was given 6 Priodax tablets by mouth. Two and one half hours later he complained of severe back pain. Examination failed to reveal any apparent pathology. 50 mg. of Demerol was given hypodermically and the patient slept through the night. His gallbladder x-rays were taken the next day, he felt fine, and his vital signs were all normal. The gallbladder failed to visualize and it was decided to repeat the test.

At 6:00 P. M. of March 17, the patient was again given 3 grams of Priodax. Within fifteen minutes he complained of severe pain in the epigastric region. Examination at this time revealed slight tenderness in the right upper quadrant of the abdomen. 50 mg. of Demerol was given but no relief was obtained by the patient. This dosage of Demerol was repeated in one hour, but still the pain persisted. At 12:30 A. M. of March 18 the Demerol was again administered and the patient vomited for the first time. The vomitus was thick,

green, and mucoid. At 1:45 A. M. morphine was required for the pain. On examination at 2:30 A. M. the only positive finding was slight tenderness in the right upper quadrant; the temperature, pulse and respirations had remained normal.

By 8:00 A. M. of the morning of March 18 the clinical picture had begun to change. Rectal temperature was now 100.8, pulse 108 per minute and respirations 28. There was marked spasm and rigidity in the right upper quadrant of the abdomen. The white count was 16,400 with 93 polys. Vomiting had persisted throughout the night and continued to be bile stained. Surgical consultation was called and a diagnosis of acute cholecystitis made; it was recommended that the patient be kept under close observation and treated medically with parenteral fluids, penicillin and an ice bag locally. By that same evening the temperature had risen to 103, pulse to 120, and white count to 20,450 with 96 polys. The patient had already received 3500 c.c. of parenteral fluids, 500 c.c. of plasma, amino acids and vitamins B and C. He was visited again that evening by members of the surgical staff who detected a large, firm mass in the right upper quadrant; the opinion was expressed that this man had a generalized infection of the gallbladder, liver and bile ducts and was an extremely poor surgical risk.

On March 19 the temperature rose to 104.8 and the white count was 23,900 with 94 polys. N.P.N. was 25 and Icterus Index 30. Supportive therapy was continued and one pint of fresh whole blood administered. On March 20 the temperature was still 104 and the blood count had risen to 26,500. At this time the bacteriological department reported that the vomitus contained many pure colonies of *B. Coli*. Streptomycin therapy was instituted and the penicillin continued. For the next two days the picture remained unchanged with the patient in extremely critical condition. Six days following the second dose of Priodax, and two days after the onset of streptomycin therapy the patient showed definite signs of improvement; the temperature fell to 101, the white blood count was 16,900 with 69 polys and the mass in the right upper quadrant had begun to recede. A slight temperature persisted until March 27 but disappeared promptly when both streptomycin and penicillin were discontinued; the patient had continued to improve during this time. On April 1 the white count was 9800 with 69 polys, the patient had been afebrile for five days and only a small mass could be palpated in the right upper quadrant; appetite and bowels were normal and the patient was up and about. He was anxious to convalesce at home and so was discharged to the care of his own physician on April 2, 1947. Four weeks later his physician reported that he had continued to be well and had no residuals of his illness.

#### SUMMARY

This forty year old male, while convalescing from a pneumonic infection, complained of right upper quadrant pain which he had noted for one year prior

to admission. X-ray studies of the gallbladder were done. The first administration of Priodax tablets was followed in two and one half hours by severe back pain, which quickly responded to 50 mg. of Demerol. The gallbladder failed to visualize.

Twenty-four hours later a repeat dose of Priodax was given, followed in fifteen minutes by severe right upper quadrant pain which failed to respond to medication. This was followed within twelve hours by signs of acute infection in the right upper quadrant of the abdomen. Medical treatment was decided upon and both penicillin and streptomycin administered, the latter because pure *B. Coli* were detected in the bile stained vomitus. The clinical course was extremely stormy for five days but improvement appeared to have set in about forty-eight hours after the onset of streptomycin therapy. Surgery was decided against because it was felt that there was cholangitis and hepatitis of severe degree in addition to the infection in the gallbladder.

After being afebrile for one week the patient was discharged to convalesce at home; his blood count was normal and only a small mass remained in the right upper quadrant.

#### CONCLUSION

1. The sequence of events in this case appear to have been more than coincidental. The first dose of Priodax produced back pain; the second dose resulted fifteen minutes later in development of symptoms which rapidly exploded into a fulminating infection of the entire hepato-biliary system.
2. More attention should have been paid to the original complaint following Priodax and the drug should not have been administered a second time to this patient.
3. We are unable to explain the mechanism of cause and effect in this case, but merely suggest that Priodax may have precipitated an acute exacerbation of a latent or chronic cholecystitis.
4. Although the evidence is meager, streptomycin may have played an important part in the recovery of this patient from a *B. Coli* infection of the hepato-biliary tract.



## THE MANAGEMENT OF CANCER OF THE CERVIX UTERI

L. G. SIMON, M.D., *South Norwalk*

IN PRESENTING the subject of cancer of the cervix uteri, I shall first outline the routine used in our clinic in the management of this condition, and then shall give you the results of our experience.

Our first concern with the patient who presents herself at the clinic is naturally the history. We use the Tumor Record form supplied by the State Association and fill it in as completely as we can. This gives us the usual information as to age, color, marital status, family, etc. In addition we emphasize the history of hemorrhage, its duration, character and severity. We also ask about previous pregnancies.

The patient is then examined abdominally and vaginally. A description of the tumor is made on the chart, noting its size, extent into the parametria and mobility. The cervix is then examined by speculum. In all cases, whether there is obviously carcinoma or not, we take a specimen for biopsy at this examination. We use the Healey forceps and obtain our specimen without the use of any anesthetic. A simple piece of tissue can be obtained in this way with no discomfort to the patient whatsoever. In case the subsequent bleeding is too profuse, we use a vaginal tampon for twelve to twenty-four hours.

The patient is then asked to return in a few days at which time the biopsy report is consulted. If the report is cancer, she is referred to the x-ray department for deep x-ray therapy to the parametria.

Upon completion of the roentgen therapy the patient is reexamined. Residual tumor tissue is looked for and another biopsy is taken in case of doubt. Where cancer is still present—as it is in most cases—radium is applied. The radium is administered in the operating room under sodium pentothal intravenous anesthesia and is applied in either or both of two forms: by means of a tandem applicator or by the interstitial use of radon seeds.

The tandem applicator consists of a rubber tube containing either 50 or 75 mgms. of radium element, depending upon the size of the uterine cavity and cervical canal. The tubes of radium are placed end

to end within the rubber capsule. The tandem is inserted into the cervical canal and uterus after dilatation. The larger dose of radium should be in contact with the cervix. The rubber dam is then sutured to the cervix to insure its stability and voluminous packing is used to keep the bladder and rectum away from the radium—thus reducing the subsequent cystitis and proctitis. The seeds are usually one or two millicuries in strength. The average intracavitary dose is over 3000 mg. hours and is delivered in from forty to sixty hours, while the radon seeds are distributed uniformly throughout the lesion bringing the total dose to about 6000 mg. hours.

Upon the completion of treatment, the patient is followed in the clinic very closely. At first every week and then less often; finally, every three to six months. At each follow-up visit a note is dictated on the patient's chart about her condition and when a suspicious area is encountered, another biopsy is taken. Frequently the patient requires additional radon seed implantation.

The results of treatment of our cases follow. The data presented here covers fifty-six cases and the period from 1934 to 1946. Actually there were more patients, but I have left out of this discussion any cases that were not corroborated by biopsy, or those that were first treated elsewhere but were inherited by us. Also the new cases.

Of the fifty-six patients, twenty or 35.7 per cent are alive now. Twelve of them (21.4 per cent) are alive over five years. These cases present all stages of the disease.

In this group, eleven patients were women under forty; twenty-four were in the fourth decade and fourteen were over sixty. The youngest patient was thirty-one, the oldest eighty.

Two of these patients had previous supracervical hysterectomies.

All of these women were married and three of them were colored.

The biopsies were graded in thirty-five of the

specimens. There were six grade one, seventeen grade two, nine grade three and three grade four. Two specimens were adenocarcinoma.

From the standpoint of duration of symptoms, this group can be considered a moderately early one. Twenty of the women had symptoms less than six months. Thirteen others had their symptoms less than one year.

Although, as just stated, this was a group of fairly early cases from the standpoint of length of symptoms, however, when we base our discussion on the clinical findings, we find that all stages of the diseases were included—from the earliest to the most advanced. Several lesions were so extensive, for instance, that no treatment at all was given—even for palliation.

Upon looking more closely at the twelve five year cured cases, we note the following: none of these had symptoms over one year, (five were under one month) four of these had microscopic grading of one—(and please remember that in our entire series of fifty-six, only six were of this grade) five were

grade two. Eight of these twelve patients were treated by radium alone without benefit of x-ray therapy and the radium dosage varied from 4062 mgh to 7335 mgh.

Fifty-six is a small series to draw conclusions from but on the basis of this small number we can infer that:

1. Early diagnosis is a very important factor.
2. The microscopic grading is a most valuable guide—there being only one cured case in grade four and none in grade three.
3. The local radium treatment alone was sufficient in eight of the twelve cases and that dosages of radium should not be less than 6000 mgh.

To summarize, I have presented an outline of our management of cases of carcinoma of cervix. I have given the results of the treatment in a series of fifty-six cases and have drawn some conclusions from them, observing at the same time, that this is a small series and that the above conclusions, although instructive, must be substantiated by a much larger collection of cases than was presented here.

## THE CONNECTICUT COMMISSION ON ALCOHOLISM

SELDEN D. BACON, PH.D., and DUDLEY PORTER MILLER, PH.D., *New Haven*

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Dr. Bacon. *Associate Professor of Sociology, Yale University*

Dr. Miller. *Executive Director, The Connecticut Commission on Alcoholism*

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AS A RESULT of action by the Connecticut State Legislature during its 1945 Session a law was passed which created a Board of Trustees of the State Fund for Inebriates, this title being changed by the 1947 Assembly to the Connecticut Commission on Alcoholism. Before describing this legislation, the activities of the Commission to date, and its policies and problems, it would seem appropriate to consider what appeared to be the major factors lying behind the passage of the act, first of its sort in this country. (Since 1945 Utah, Wisconsin, Oregon and the District of Columbia have passed very similar legislation; other states have created commissions to study the problems.)

Connecticut has been mental hygiene conscious for a long time, the Mental Hygiene Movement originating in this State. Furthermore, Connecticut

has been officially aware of the problem of inebriety since 1830 when the first report on the subject with recommendations for action was made to the legislature. The most ambitious program of the State was to be seen in the establishment of the State Farm for Inebriates which was closed in 1941 on grounds of inefficiency and expense. The loss of this facility was important in recreating recognition of the problem among police officials, judges, and penal administrators.

Of immediate importance in the war years was the matter of industrial manpower. As one of the most industrialized areas in the world, Connecticut was desperate for workers. Attention was finally called to the large jail population which was almost entirely made up of non-soldiers between thirty and sixty years of age of whom 70 per cent were incar-



erated because of drunkenness. Thousands of men were involved annually, a most frustrating situation to would-be employers in a period of labor shortage.

Between 1940 and 1943 two surveys were published on drunkenness: one on crime and inebriety in Hartford, the other on the extent and nature of drunkenness in the State, each issued by an official body. The recommendations in the latter study were almost wholly incorporated in the new law.

A minor factor may have been the fear of a future increase in alcoholism following demobilization.

Of specific importance in influencing the form and techniques which were subsequently incorporated in the law were two developments, one national, the other at that time primarily of local significance. These were, first, the rise of interest in Alcoholics Anonymous, and second, the presence of the Yale group of researchers in the field of alcohol and its problems. These groups suggested possible ways of meeting the problem, ways which were already in operation. The Yale group, aided by the Connecticut Prison Association had established two clinics for alcoholics in the spring of 1944, and their work was even then achieving national reputation.

Finally, although the evidence is not too clear on this point, representatives of the liquor industry expressed to the state government their willingness to accept higher licensing fees to pay for at least an experimental program to deal with the problems of alcoholism.

The Commission is composed of five members all of whom are appointed by the Governor of the State for five year terms. At least two members must be physicians licensed to practise medicine in Connecticut. Members of the Commission meet at least once each month; three members constitute a quorum. They receive no compensation but are reimbursed for their actual and necessary expenses. Members annually elect from their number a chairman, vice-chairman, and a secretary.

The present membership of the Commission is as follows: Chairman—Selden D. Bacon, PH.D., Yale University; Vice-Chairman—Dr. Arthur H. Jackson, Washington, Connecticut; Secretary—Mrs. Edna A. Edgerton, Stamford; Member—Dr. Charles T. Bingham, Hartford; Member—Judge George C. Conway, Guilford; Executive Director—Dudley Porter Miller, PH.D., New Haven; Medical Director—To be appointed.

The duties of the Commission are to study the problems of alcoholism, including methods and

facilities available for the care, custody, detention, treatment, employment, and rehabilitation of alcoholics; to promote meetings for the discussion of problems confronting clinics and agencies engaged in the treatment and rehabilitation of alcoholics, and to disseminate information on the subject of alcoholism for the assistance and guidance of residents and courts of the State.

The Commission, with governmental approval, is authorized to purchase, rent, or lease land, buildings, and equipment deemed necessary and suitable for carrying into effect the provisions of the law. If no such land or buildings are available, the Commission, with governmental approval, is authorized to purchase in the name of the State a suitable building site and enter into contracts for the construction and equipment of buildings thereon as may be necessary and adequate for the care, custody, and treatment of persons who voluntarily seek assistance and of persons committed to the custody of the Commission by court order. Toward this end the Commission is authorized to borrow from the General Fund a sum not to exceed one hundred thousand dollars as a temporary loan to be discharged from the funds available in the Inebriate Fund or from funds appropriated to the Commission by the General Assembly. The management and control of such land, buildings, equipment, and facilities so acquired rest with the Commission, its financial affairs being conducted in accordance with state fiscal procedures as prescribed by law.

To support the work of the Commission on Alcoholism, nine per cent of all the moneys received by the Liquor Control Commission as fees for permits under any provision of the Liquor Control Act are turned over to the State Treasurer who deposits them in a separate fund known as the Inebriate Fund. Current income from this source amounts to about \$200,000 per annum.

The Commission may accept or refuse on behalf of the State any gift or valuable thing for any purpose connected with its work which shall be received and held by the Treasurer of the State as part of the Inebriate Fund.

The superior court, any criminal court of common pleas, any town or municipal court, or any justice of the peace having criminal jurisdiction, and any probate court may commit to the custody and control of the Commission for a period of not less than four months, nor more than three years, any habitual drunkard or any person who has been

three times convicted of intoxication in any such court, or who has lost the power of self-control from the intemperate use of intoxicating liquors.

Any person committed to the Commission may, notwithstanding the terms of any order of commitment, be permitted to go at large on probation and without custody or restraint, for such time and under such conditions as the Commission shall judge best.

The managers, trustees, or directors of any State inebriate asylum may receive any habitual drunkard who shall apply to be received into such asylum, retain him not more than one year and treat him in the same manner as if committed by the court of probate.

The Medical Director of the Commission may bring commitment proceedings in the probate court in the district wherein the Commission maintains an inebriate asylum, for commitment to such institution as such court may direct, of any person who has been committed to the custody and control of the Commission and who is mentally ill.

After taking into consideration the patient's ability to pay, the trustees of the State Fund for Inebriates shall determine the amount that each person shall pay for treatment and services furnished by the Commission and shall collect from the patient or any person liable and able to contribute to his support the amount due for such treatment and services. All moneys received by the Commission as payment for treatment shall be turned over to the State Treasurer, who shall deposit the same in the fund established as provided by law.

On or before December 1 in each even numbered year, the Commission shall render a report to the Governor and the General Assembly of its activities, including recommendations for improvements therein, by legislation or otherwise.

The Commission has a long range function of education, of research, of therapy, of community services and, finally, of prevention. In point of time, therapy and community service will come first. It would seem essential in a new project of this sort that there should be adequate evidence for the public that the Commission can produce results, that a measurable service is being rendered. The fact that the research center at Yale is immediately available and is completely cooperative makes the work of the Commission far easier.

In relation to therapy, the Commission is interested primarily in establishing methods and facilities

which will be useful for the majority of alcoholics; it is not interested in dealing solely with or chiefly with particular types, such as the psychotic, or the wealthy, or with any other special type. However, the Commission is limited by its budget and cannot plan to help all the alcoholics in the State directly and immediately. Therefore, it is projecting a quality rather than a quantity program.

Again in relation to therapy the Commission is aware that the alcoholic cannot be "cured" in the strict sense of that word. Cure would imply that the compulsion behind excessive drinking would be eliminated, that the progressive stages of the alcoholic syndrome would be stopped, that the physical, psychological and social maladjustments which are part of the total picture would be eliminated and a state of adjustment achieved, and that the individual could live a relatively adjusted life including the use of alcoholic beverages. In terms of the experience of researchers, of various agencies, and of alcoholics themselves strict cure appears impossible in the light of present knowledge and techniques. The Commission's immediate program, therefore, is designed to stop the drinking, to break the progressive cycle, and to develop a physical, social and psychological readjustment of the alcoholic to the extent that the individual can live without alcohol as a relatively adequate person in his or her own eyes and in the eyes of the community.

The Commission feels that alcoholism is a condition of the total personality in its relation to society. Therapy, therefore, is a procedure involving medicine, psychiatry, psychology, and the many aspects of social readjustment. It is not just a medical, just a hospital, just a social work, just a vocational readjustment or just a psychiatric program, or any such specific set of procedures. Therapy for the alcoholic is a community health program calling for treatment of a diseased condition of the total personality. As such, it may only be attained by a widely conceived program which is designed to utilize many specialties and all relevant community resources.

The Commission realizes that its work is in many ways, if not most, experimental and must be sufficiently flexible to profit by unfolding experience and to meet needs as yet unrecognized.

In relation to prevention: It is felt that prevention of alcoholism will not follow upon dictates from those in high places but rather will develop as the nature of alcoholism is more fully understood by an ever growing sector of the general public. This



understanding will grow not through didactic methods but through an appreciation of the possibilities and realities of rehabilitation. As knowledge of such rehabilitation work increases, it will become more and more possible for those in the earlier phases of alcoholism to seek help; it will become more and more difficult for people to ridicule, scorn and punish these sick people, it will become possible for reasonable, calm and effective responses to supplant the hysteria, escapism and unconscious cruelty which now too often hold sway. Just as the dramatic demonstrations by Lister and Pasteur led to a general acceptance of more efficient behavior in personal cleanliness and public sanitation, so may the successful rehabilitation of alcoholics lead to more efficient behavior and attitudes by individuals and by groups in relation to the drinking of alcoholic beverages and to the disease of alcoholism.

The Commission is planning an extensive program for the rehabilitation of alcoholics in Connecticut. The establishment of outpatient clinics for the care of alcoholic patients on an ambulatory basis is planned for the major population centers of the State. Inpatient services for patients needing bed care are envisaged on a cooperative basis with existing hospitals. A facility is planned for the care and detention of involuntary patients who present a long history of court appearances for drunkenness and who prove unresponsive and uncooperative to treatment on a voluntary basis. The Commission envisages an educational program designed to acquaint the people of the State with the nature of alcoholism, the newer methods of its treatment and prevention, and how and where assistance to patients with alcoholism can be secured. Toward these ends, the Commission hopes to enlist the cooperation of existing and relevant social agencies—private or public—in its efforts to bring every available resource to bear on the problem of rehabilitating alcoholics and the prevention of alcoholism.

Among the first steps taken toward achieving its plans, the Commission, on March 1, 1946, established its administrative headquarters office at 110 Whitney Avenue, New Haven, under the direction of the executive director. On July 1, of that same year, the Commission established, in Hartford, the country's first state-supported outpatient clinic for the treatment of alcoholics. Subsequently, by contractual relation with the Yale Plan Clinic, similar services were established in New Haven. In addition, land has been purchased and plans are under-

way for the erection and establishment of a combined inpatient and outpatient unit in Hartford. In this facility patients will receive full medical, psychiatric, and nursing care. The facility will serve as a center for study and research on effective therapies and on the problems of alcoholism in general. The Commission hopes to open a third outpatient clinic before 1948; this will depend entirely upon the availability of psychiatric personnel.

Each outpatient clinic is under the direction of a clinical psychiatrist who is assisted by two psychiatrically trained mental hygienists and two clerical workers. In addition to this full-time staff the consulting services of a psychologist, a medical internist, and a laboratory are available for use when special and involved diagnostic testing procedures are indicated for particular patients.

Current operating expenses for a single outpatient unit for all services, including salaries, rent, and supplies, approximate \$22,000 per annum. It is estimated that similar and additional services for the proposed inpatient and outpatient facility will call for an annual operating budget of \$90,000.

The Commission operates on the principle that the alcoholic is an individual with a badly adjusted personality who shows a progressive dependency on alcohol as a symptom or as a means of compensating for the maladjustment. Alcohol may or may not have played an important rôle in the earlier stages of the maladjustment, but inevitably made the total adjustment of the individual worse and also added characteristics and behavioral sequences to the individual's personality which quite obviously distinguish alcoholism from other ailments. Although no two alcoholics are identical and although no specifically alcoholic personality pattern has been established, certain characteristics of the fairly advanced stages of the condition can be labeled and are useful for classifying therapeutic work:

(1) On the physiological level, alcoholics are characteristically more susceptible to disease and to accident than is the general population; furthermore, their rate of recuperation is slower, partly due to their often run-down condition, partly due to the characteristics to be listed below. Until these problems are met, overall rehabilitation is difficult to achieve. In addition, general medical attention is often a useful means of gaining the interest and necessary cooperation of the patient. Many cases need medical attention for post-binge conditions—tremors, hyperactivity, nausea, etc. Hospitalization

may be needed for some cases, temporary convalescent facilities for a good many.

(2) On the psychological level, alcoholics show characteristics of an immediate nature and of a more basic continuous aspect both of which must be met if rehabilitation is to be achieved. The exaggerated remorse and guilt feelings which are almost universal among alcoholics, although sufficiently hidden to fool friends and acquaintances, must be relieved, a certain degree of realistic confidence in the self must be established, and a desire to regain control of one's own destiny with a plan and under guidance must be acquired if treatment is even to start. More basic than these, however, are the underlying personality difficulties. In some instances, perhaps in many, only superficial psychiatric guidance may suffice; in fact, too deep probing may be contraindicated. In other instances psychiatric therapy of a deeper nature is essential if more than a temporary cessation of the symptom of chronic excessive drinking is to be attained.

(3) On the social level, alcoholics in the more advanced stages of the condition are characteristically under-socialized: they are unmarried or divorced or separated or widowed; they are without close friends; they move from job to job, from residence to residence; they are without recreational or religious or community ties. This social isolation plays a large rôle in their immature, egocentric, and often escapist modes of behavior. A more useful and realistic adjustment to the social world around them must be developed. Naturally, this cannot be done over night or by magical techniques. It requires a careful evaluation of the social assets and liabilities of the individual and of his envisaged social milieu. In the beginning rehabilitation calls for considerable planning, protection, and reinforcement until the individual can assume a more mature, independent, socially reciprocating and responsible rôle in ordinary community living. In addition to this general, basic problem of social adjustment there are immediate problems which loom large on the alcoholic horizon and which, along with the post-binge physical condition, may have been the proximate cause of the patient's appearing in the court or clinic. A divorce action may be pending, creditors may bring action, a foreclosure is imminent, there may be no bed, no money for a meal, glasses broken and no hope of a job without them, no clothes, and so on through a long list of situations well known to most alcoholics. Unless some resolution of such

difficulties appears possible, the chances of establishing any course of effective treatment at all are remote indeed.

(4) Finally, the specific act of drinking itself must be stopped, the type of drinking (when, what, where, how much, with whom, under what circumstances) diagnosed, and a plan of activities and active support be instituted.

With these different levels of diagnosis and therapeutic procedure it is essential that the internist, psychiatrist, psychologist, and mental hygienist or psychiatric social worker act as a team. Furthermore, they will often need to call on resources in the community outside the clinic such as Alcoholics Anonymous, the hospital, the Family Service Society, Veterans Center, and various governmental facilities.

Any individual, male or female, who is a resident of the State of Connecticut, and who is in any way afflicted with alcoholism will be accepted by a clinic up to its capacity.

The clinic operates on an appointment basis. Appointments are arranged according to the needs of the individual case. In emergency cases, appointments are given immediately.

The first appointment for any patient in the clinic is an important one both to the patient and to the clinic. In this first contact an attempt is made by the intake worker to assess the patient's problem in terms of his immediate needs and to determine whether the patient is a hopeful candidate for psychiatric therapy. The latter technique involves an evaluation of the patient's general psycho-biological resources and also an evaluation of the patient's understanding that his drinking is a manifestation of underlying psychological or character disturbances. This evaluation is only a phase in the total examination procedure and is, by necessity, continuous with subsequent psychiatric interviews with the psychiatrists and mental hygienists.

To meet the immediate needs of the patient, the staff needs to obtain as much general information from the patient as he is able to present in this first interview. The technique used does not follow any systematic outline but is dictated by the problems presented by the individual case. In situations where the interviewer feels that immediate medical attention is indicated, the individual is seen by the physician in charge.

A patient who does not need immediate medical



attention is given his next appointment with the physician for a thorough physical examination which includes blood serology, urinalysis, and neurological examinations. In cases where special examinations are indicated, such as cardio-vascular studies, electroencephalograms, endocrine workups, and so on, the patient is referred to a proper agency. Routine laboratory analyses are performed by the Bureau of Laboratories, State Department of Health. Selected patients presenting problems in need of specialized attention are referred to the psychologist or to the medical internist.

Patients are referred to the clinic by a variety of municipal, state, and federal social agencies. The largest number of patients thus far seen in the clinics are self-referred. The second largest number has come from the courts. With the exception of the self-referral cases, information about the patient is given at the clinic before the patient arrives for his first appointment. A social agency referring a case sends its summary of the case to the clinic. This summary includes a resumé of the agency's knowledge of the patient, a statement of the patient's present difficulties as they relate to alcoholism, the agency's reasons for referring the patient, and any other information which it feels is pertinent to the patient's problem.

During its first year the Hartford Clinic averaged

just under twenty new cases a month, somewhat less than planned due simply to the difficulty of obtaining adequate personnel. The Yale Plan Clinic through a contractual arrangement has taken on in addition to its regular patients an average of eleven new cases a month, these coming entirely from the New Haven City Court. By July, 1948, the Commission hopes to be receiving about eighty-five new cases a month.

The Commission is now engaged in establishing a contractual arrangement which will make convalescent facilities available to patients from the New Haven area.

In concluding this brief description of the Connecticut Commission on Alcoholism it must be emphasized that this is a new and frankly experimental service, not only new for any state government but, with the exception of the Yale Plan Clinic, new for any organization public or private. Consequently the policies, organization, and procedures are flexible, and subject to change. As psychiatric personnel becomes more available, as experience is gained, and as public attitudes gradually evolve toward a more rational, effective, and humane viewpoint, the work of the Connecticut Commission will present a clearer picture of what can be accomplished by a state commission in meeting the many problems of alcoholism.

## THE LIBEL SUITS OF THE AMERICAN MEDICAL ASSOCIATION

MORRIS FISHBEIN, M.D., *Chicago*

(Concluded)

### THE OPEN-AIR SHOW

One of Baker's advertising stunts was characteristic of a man who had been in the "show business." He broadcast that the Baker Institute would hold an open-air meeting at Muscatine, where it would be demonstrated that both external and internal cancer was curable by the Baker methods. In the June issue of *T N T Magazine*, it was claimed that 32,000 people attended this meeting. In the same issue he purported to describe some of the "wonders" that were shown at that time. One of the more spectacular was thus described:

"Most amazing and remarkable of all, the entire top portion of the skull of a patient almost in the last stages of cancer was removed and held up for exhibition by the physician before the gasping throng exposing the brains of the entire top of the patient's head."

### BAKER'S "EXPERTS"

When the time came for Norman Baker to submit testimony to rebut that which had been put in by the American Medical Association, he called to the stand certain alleged experts. The first of these was E. M. Perdue, M.D., of Kansas City, Mo. Perdue

qualified as an "expert" on cancer by stating that he had done special research at Johnson's<sup>3</sup> Laboratory for Cancer Research at Kansas City, Mo. According to Perdue, the cancer cell differs from the normal cell in that it contains more water, and the way to kill cancer is to remove the water from the cancer tissue! This is done, said Perdue, by applying escharotics or by injecting "certain chemicals which substitute that water and take it out, and the cancer dies."

Perdue testified that he had never done any surgical work for cancer nor had he ever used radium or x-ray, and that he would use none of these methods of treating cancer. He said that he had used escharotics in the treatment of cancer and he submitted as an efficient formula, equal parts of powdered zinc chloride, powdered gum acacia, powdered sanguinaria, powdered galingal and powdered charcoal. According to Perdue, a product of this sort "deaquafies" the cancer, "taking the water out by substituting another chemical for it." Furthermore, according to Perdue's testimony, when escharotics are applied, they do not destroy normal tissue, because the cancerous tissue is selective. Perdue declared that the development of cancer was due to an increased alkalinity in the tissues of the person suffering from this disease.

On cross-examination it was brought out that Perdue not only approved of the Koch treatment for cancer, but of the Abrams "electronic" theory; further, that he was using, at various times, what he described as the "Ellis machine," which is apparently one of the many imitations or modifications of the Abrams device. George Starr White<sup>4</sup> is a personal friend of his, said Perdue, and has taught him "lots of things in diagnosis." Perdue testified that he studied law at the same time that he studied medicine; that he began the study of medicine at the Kansas City Hahnemann Medical College and that he taught histology, anatomy, and dissection at the same time. "I was a good anatomist," he admitted, and when asked where he learned his anatomy, he said that it was part of his course in the Kansas Normal College. He claimed, also, to have gone to the Eclectic Medical University of Kansas City. It was brought out that although Perdue has for years been practicing in the State of Missouri, he holds

no license from the state board of that state; he claims that he has a right to practice because he had been in practice twenty years prior to the time that the law went into effect. Perdue also claimed to be a civil engineer and a chemist; to hold the degree of M.D. from two schools—one homeopathic and one eclectic; to have the degrees of Doctor of Public Health from the Eclectic Medical University of Kansas City. He also took "courses" in osteopathy and chiropractic in Kansas City schools now out of existence. He claimed to be an authority on mixing concrete and declared, under oath, that he had "superintended millions of dollars' worth of public work," having laid miles of asphalt paving. He did this civil engineering in the "summertime, between the school sessions."

Another Baker "expert" was J. W. Seip, M.D., of Erie, Pa. Dr. Seip was seventy-two years old, a graduate of Jefferson Medical College, 1883, and licensed to practice in Pennsylvania. Dr. Seip admitted that his practice, up until the time of the world war, had been largely general, but "since then, it has been more psychologic and chronic diseases." He said that he "had never done much of any research work on cancer" but, nevertheless, it was his expert opinion that cancer resulted from the "present devitalized condition of our diet" by which "we rob our blood of its known necessary twelve tissue salts." Dr. Seip further was of the opinion that persons suffering from cancer were nearly all "shallow breathers" and that they were the people who were "living on white bread depriving themselves of the salts of our tissues, which are mainly in bran." He declared: "One reason why cancer is so prevalent today is because people eat white bread, and the whiter the bread, the sooner you are dead." The doctor said that in his own treatment of cancer his "principal reliance is upon the Koch antitoxin." The Bureau of Investigation has in its files advertisements from Erie (Pa.) newspapers of fifteen years ago, reading as follows:

#### ERIE'S ONLY

Permanent Office Specialist  
For Chronic Diseases

Cures high blood pressure, rheumatism, neuralgia, varicose veins and ulcers, scars and strictures, hemorrhoids, weakness, debility, nervousness, etc., without pain.

HOURS: 1 to 4 and 7 to 9 P. M.

DR. SEIP

1031-33 State Street.

3. The Johnson cancer concern is dealt with in the pamphlet "Cancer Cures and Treatments" issued by the Bureau of Investigation of the American Medical Association.

4. See article: "George Starr White—Quack," The Journal A. M. A., April 13, 1929.



A third "expert" called as a witness by Norman Baker was Bruce Miller.<sup>5</sup> He testified that he was graduated in 1886 by the College of Physicians and Surgeons, Chicago; that he was "out of practice for quite a number of years" but that in 1926, he went to Taylorville, Ill., where he was connected with Harry Hoxsey and his "Hoxide Institute." He practiced for a short period right after graduation and then worked in a factory and as a paper-hanger from 1891 to 1898; that he then "built up quite a large orchestra of ladies, dummies, in connection with a pipe organ" and went to Europe, where he took his "dummy" troupe and exhibited his "automatic orchestra." He was in Europe from 1899 to 1906, when he returned to the United States and entered the real estate business, in which he continued until about 1918. Dr. Miller testified that the only treatments he administers for cancer are escharotics and that he does not attempt to treat any cases of "internal cancer," although he admitted that cases of that kind were accepted and the patients were given narcotics to make them comfortable.

The fourth "expert" called by Norman Baker was Harry Hoxsey himself. Hoxsey testified that he was thirty years old and that his education had not extended even through the eighth grade; he then worked as a coal miner and, in 1921, he started in the cancer-cure business at Taylorville, Ill. Hoxsey testified that he went to Muscatine with Norman Baker in March, 1930, and stayed at the Baker Institute until September 4, 1930, on a percentage contract basis. He admitted that he treated many patients and even used the hypodermic needle and gave some injections. It was brought out on cross-examination what had been generally known through the newspapers—that Hoxsey and Baker had a disagreement. Hoxsey's explanation of leaving Baker was:

"I told Mr. Baker I refused to be a party any longer to bringing people there to take any other treatment only mine because he had shown no results with any other treatment on external cases and I would truthfully say not one, for I haven't seen one single case of external cancer cured there where the powder was not used."

He complained that Mr. Bellows, instead of sending the cases that come in for Hoxsey's powder treatment, would "consign them to the needle department where the intramuscular treatment was used." Hoxsey declared that he had sworn: "I have

not seen one case of internal cancer leave that institution Baker Institute as cured that did not take my cancer treatment."

Following Norman Baker's "experts," there were put in evidence a number of alleged cases of cancer that were said to have been cured at the Baker Institute. Most of these were of a superficial type and those of the so-called internal type were not satisfactorily diagnosed as cancer. Baker put on the stand some of the individuals who were alleged to have been cured and, at the same time, presented photographs of the "before-and-after" type as confirmatory evidence. Incidentally, during the closing days of the trial, the United States Marshal took a loaded .38 automatic pistol from Norman Baker. Baker's excuse was that he had a permit to carry one, but he was informed that his permit did not extend to the federal courts.

#### THE CLOSING ARGUMENTS

In the final arguments, Mr. Dutcher, for the American Medical Association, made no attempt to soften the charges that had been made in *The Journal* and *Hygeia* regarding Baker. "We called Baker a quack and we are not here to apologize for it," Mr. Dutcher declared. He brought out, further, that the State of Iowa had enjoined Baker from practicing medicine without a license and that the Federal Radio Commission had revoked Baker's broadcasting license, because it found that his operation of the station was inimical to the public interests. He reviewed the history of the five "test" patients that Baker had sent to Ozias at Kansas City, Mo., and emphasized the fact that they were all dead at the time that Baker was declaring, either directly or by implication, that they had been cured. Mr. Dutcher maintained that there was not a single case in the record of the trial in which the Baker Institute could even claim to have cured a case of cancer with its hypodermic injections. Counsel also referred to the fact that Hoxsey and Gearing, neither of whom had any medical training, were known as "Doctors" at the Baker Institute.

Mr. Dutcher also asked why Gearing and Dr. Ozias and numerous other doctors who had been connected with Baker had not been called by Baker to testify in the case. As Mr. Dutcher stated, not a single M.D. who was associated with the "institute" before the date of publication of the alleged libelous articles had been called to testify, except Dr. Statler, who still had a job there. He dwelt on the evidence in the records showing that Statler once cut a

<sup>5</sup> Bruce Miller is discussed in the article, "The Hoxide Cancer Cure," already referred to.

woman's breast under the direction of Hoxsey and that in another case, Hoxsey himself cut the breast and the patient died five days later. Mr. Dutcher also dwelt on the case of the young Iowa farmer, who, suffering from what he thought might be cancer, went to the Baker Institute, where Hoxsey started to "treat" him. Not being satisfied that the Baker Institute knew much about his case, the young man went to the State University of Iowa's Dermatologic Clinic, where they found he was suffering from "barber's itch"! This case, as some of our readers may remember, was the subject of a brief article in this department of *The Journal* for July 26, 1930.

Baker's attorneys, in their closing speech to the jury, declared that the American Medical Association was malicious in attacking Baker and that it had no right to attempt to interfere with Baker's business or injure his reputation.

The case went to the jury as the court closed on the evening of March 2; the jury was out for a few hours that evening before adjourning for the night. They returned to the jury room at nine o'clock the next morning, and at 10:50, a ballot was taken and the vote was unanimous for the American Medical Association. Their brief formal report to Judge Nordbye was: "We, the jury, find for the defendant."

Subsequently to losing the suit in Iowa, Baker went to Eldorado, Arkansas, where he opened another cure for cancer in an old springs resort. Here he practiced his method, exploiting it with a radio station across the border in Texas for which the call letters were X.T.N.T. Eventually he was tried by the Post Office Department and the government for the promotion of a fraudulent cancer cure and was sentenced to four years in the penitentiary. Shortly after he emerged from the penitentiary, he attempted to launch a fraudulent health institute in Iowa. Once a quack, always a quack!

#### "PAINLESS" PARKER

Early in 1945 while making an address in California before the Oakland Forum and the California Dental Association, Dr. Morris Fishbein characterized Dr. Painless Parker, a dentist, as a charlatan and a quack. Dr. Parker filed suit for \$100,000, which suit was subsequently dropped.

Painless Parker operates a series of dental offices in California. His name had originally been something else but he got it changed to "Painless" Parker

so that he could use the word "Painless," which word is contrary to the law in many states.

#### CHARLES R. WILEY

In June 1935 suit was filed against the American Medical Association by Dr. Charles R. Wiley, practicing medicine in Chicago under the name and style of the Civic Medical Center, asking a large sum of money for damages and for libel. That suit was withdrawn.

#### JEAN PAUL FERNEL

There have been several suits by Jean Paul Fernel against the American Medical Association and Morris Fishbein requesting at various times damages of \$1,000,000 or more for alleged libel.

#### FERNEL'S PROFESSIONAL RECORD

John Paul Fernel's name originally was Giovanni Furno. He was born in Italy in 1889 and was graduated by the Illinois College of Medicine in 1911, receiving an Illinois license the same year and a Michigan license, through reciprocity with Illinois in 1916. Furno's Illinois license was first revoked in June, 1920, because of dishonorable conduct. Furno's license was restored by the Illinois board in 1922 during the tenure of office of the notorious W. H. Miller, who was later convicted of selling licenses and removed.

For some time prior to 1916, Furno lived in Chicago. About that time he went to Michigan and opened an office in Detroit. In June, 1919, *The Journal* received a request from the Detroit authorities for information regarding Furno, who, it was alleged, was at that time advertising (as "G. Furno") to treat "nervousness, manly weakness and any other blood disease." Later, according to Detroit officials, Furno was served with a warrant and brought in to the police court, where he pleaded "Not guilty," was bound over to a higher court under \$500 bail and, before the case was called to the higher court, "jumped his bail" and left the state. The Detroit officials reported that Furno's method was to get foreigners as patients and compel them to disrobe and enter an adjoining room for physical examination, and while this was going on a confederate (Furno's alleged wife) went through the pockets of the victim to determine the amount of the fee it was possible to obtain. As the results of these methods, the Detroit papers recorded in July, 1919, that nine of Furno's patients started suit against him.

Another part of Furno's scheme, according to the



Michigan authorities, was that of collecting additional money from those of his victims who had not reached the limit of their donations, by purporting to have a blood examination made. The Michigan authorities sent the American Medical Association some of the "analytical reports" said to have been used by Furno in furthering this scheme. These bore the legend "International Medical Laboratory, Columbus Building, 32 North State Street, Chicago, Ill." There was no such concern as the "International Medical Laboratory," nor any Columbus Building at 32 North State Street. There is a Columbus Memorial Building at 31 North State Street, but there was not and never had been such an institution as the "International Medical Laboratory" in this building.

From Detroit Furno came back to Chicago, and, in October, 1919, is said to have entered into an agreement with a Chicago "plastic surgeon" (of the advertising type) to be taught the gentle art of removing sagging cheeks, baggy eyelids, hump noses, wrinkles, etc. While his preceptor was on a trip out of the state, Furno is said to have seized the opportunity to copy a list of the "plastic surgeon's" patients. On the return of the man from whom he was taking lessons, Furno discontinued his instruction and opened up a competing office in the city of Chicago. This, too, in spite of the alleged fact that he had entered into a contract not to practice "plastic surgery" in Chicago.

In the latter part of 1923, Furno, under his new name Fernel, corresponded with the Michigan authorities, seeking information regarding another Chicago physician who was apparently his most active competitor in the plastic surgery field. This other individual, like Fernel, had previously been in trouble in Michigan, and, also like Fernel, had "jumped his bail" and left the state. Also he obtained an Illinois license during the Miller régime. The fight between these two "plastic surgeons" was a spirited one, but Fernel's competitor, while having a professional record far worse than Fernel's, seems to have kept the upper hand—so far.

On another occasion he promoted a fraudulent bust developer called "Landa" and on still another occasion a vitamin fraud and a device called the "sleeping brassiere" which contained small, rubber sponges to be worn over the breast and which were soaked with a mixture of various salts and chemicals which were said to be useful in making smaller an oversized bust.

Fernel was in trouble in 1942 when the Circuit Court upheld the action of the State Department of Education and Registration which revoked his license to practice medicine in Illinois. He was in trouble in 1943 for violation of the Federal Food, Drug and Cosmetics Act and he was sentenced at that time to one year in the County Jail and ordered to pay a fine of \$500. In 1944 he was again in trouble for violating the Federal Food, Drug and Cosmetic Act and the Circuit Court of Appeals in 1944 affirmed the sentence given by the lower court. Then on December 29, 1944, he was sentenced to prison for three years following his conviction by a jury on twenty-one charges of violating the Food and Drug Act, carrying on a mail order medical business from his home at 1543 N. Wells Street, Chicago.

#### HERBERT EDWIN SOULE

A suit for some millions of dollars was filed by one Herbert Edwin Soule in 1936 against the American Medical Association claiming libel. Soule was reported to be president of the high-sounding National Health Foundation of Minneapolis. He was widely known for his antivivisection and anti medical propaganda. During the war he gave considerable trouble to the armed forces by his campaigns against inoculations such as were used by the Army to prevent disease among the troops. His suit never was pressed.

#### ROBERT WADLOW

In 1937 and 1938 came suits by Robert Wadlow, a giant, who claimed that he had been libeled by an article published in *The Journal of the American Medical Association*. The case came to trial in 1939 in St. Joseph, Missouri. Robert Wadlow claimed that he had been libeled in an article published in *The Journal of the American Medical Association* which referred to him as a freak. *The Journal* produced several other giants on the witness stand who claimed that they knew they were freaks and made a living at it. A newspaper said, "The parade of giants through this city's federal courtroom, streets and hotel lobbies was climaxed last night when a jury decided against 8-foot, 8-inch Robert Wadlow in a \$100,000 libel suit."

Robert Wadlow died in July 1940 when he had an infection in his foot and did not know about it for several days due to the fact that he had lost sensation in his legs, apparently associated with his rapid growth. The boy had weighed 8½ pounds at birth.

At the time of his death he was 8, 9½ inches tall and weighed 491 pounds and was definitely credited with being the world's tallest man.

#### EDNA PURDY FERNEL

In 1938 Edna Purdy Fernel sued the American Medical Association for \$100,000. Her case is described in the story of Jean Paul Fernel mentioned previously.

#### ASA BRUNSON

In 1938 came a trial of the case of Asa Brunson vs. Morris Fishbein for \$300,000 libel. This case was tried in the courts at El Paso, Texas, and dismissed by the judge on the fifth day with a fine statement praising the American Medical Association for its attempts to expose quackery. Brunson claimed to be able to cure tuberculosis with a mixture that contained petroleum. A leading periodical was about to publish an article exploiting him when it withdrew the article following a statement by the American Medical Association. Brunson claimed he had been damaged to the extent of \$300,000 by failure to publish this article.

#### HIRESTRA LABORATORIES, INC.

In 1938 (April) also the American Medical Association was sued by the Hirestra Laboratories of New York for \$1,000,000 because of an editorial in *The Journal* which characterized its product "Endocrine" as "a cosmetic with a menace." Endocrine claimed to contain 0.625 mg. of estradiol per ounce. *The Journal* editorial had pointed out the possibility of harm from such a preparation. Such preparations if they contain a sufficient amount of female sex hormone to have an effect are potentially dangerous; if they do not contain enough to have an effect they are fraudulent.

Later came another case by the Hirestra Laboratories for \$3,000,000 for conspiracy and libel and then still another suit for \$3,000,000 on the theory of conspiracy and libel.

All these suits were withdrawn.

#### WILLIAM E. BALSINGER

A plastic surgeon named William E. Balsinger sued the American Medical Association in September 1938 seeking \$100,000 for libel. Balsinger, who is a plastic surgeon, claimed that he had been restricted in his freedom of practice. Incidentally both Balsinger and Henry J. Schireson claimed that they were the ones who straightened Jack Dempsey's

nose. At various times Balsinger had been sued for malpractice by patients upon whom he had operated. The records of all of these cases are available in the files of the American Medical Association. The Balsinger cases have never come to trial.

#### JEAN FERRELL, INC.

Jean Ferrell, Inc., had tried by a threatened libel suit to prevent the American Medical Association from giving the public the facts relative to its "Corcentra Food" which was a mixture of rhubarb, soy bean meal, Irish sea moss, gravel root and dehydrated cranberries. Jean Ferrell was also a cosmetic concern and manufactured another food known as "Bio-vita." The Federal Food and Drugs Administration had obtained judgments against the organization as had also the Federal Trade Commission. In fact, the Food and Drug Administration reported that "Corcentra Food" was adulterated, misbranded and falsely and fraudulently represented. The company was fined \$2,000.

#### J. THOMPSON STEVENS

In 1940 damages of \$600,000 was sought for libel from Morris Fishbein and the American Medical Association by one J. Thompson Stevens who has been described in the *Cosmopolitan Magazine* in an article by Rex Beach as a "miracle man." *The Journal of the American Medical Association* published an editorial against unwarranted exploitation of J. Thompson Stevens and his methods. He also filed another suit for \$350,000 for libel. These cases never came to trial.

#### JEAN PAUL FERNEL

In 1941 came another attempt by Jean Paul Fernel to collect \$3,000,000 for libel. Nothing came of this.

#### WAYNE COUNTY ASSOCIATION OF PHYSICIANS AND SURGEONS OF OSTEOPATHIC MEDICINE, INC.

In 1942 the Wayne County Association of Physicians and Surgeons of Osteopathic Medicine, Inc. sued Dr. Morris Fishbein because he had made the statement in a lecture given in Detroit that osteopaths were not acceptable as physicians in the United States Army Medical Department. This case was withdrawn.

#### DINSHAH P. GHADIALI

The Association was also drawn into a considerable number of suits filed by the United States of America against one Dinshah P. Ghadiali who has repeatedly threatened suits against the American



Medical Association because of articles published in the columns of its *Journal* relative to his promotions of bogus apparatus for treating disease by a system called "Spectro-Chrome Therapy." Ghadiali was also founder of the Spectro-Chrome Institute. He holds the degrees of doctor of chiropractic, doctor of philosophy and doctor of legal law. He is a fellow and ex vice-president of the Allied Medical Association of North America, member and ex vice-president of the National Association of Drugless Practitioners, president of the All Cults Medical Association, president of the American Association of Spectro-Chrome Therapists, president of the American Anti-Vivisection Society, member of the Anti-Vaccination League of London, and member of the American Association of Official Surgeons.

Colonel Ghadiali (for he claims to be a Colonel) has a most interesting history. In May, 1925, he was arrested after a pistol battle in Portland, Oregon, charged by the federal authorities with having transported a nineteen year old Portland girl from that city to Malaga, New Jersey, and back for immoral purposes. He was indicted on six counts and found guilty of them all. At the time of his trial it was reported that the girl was engaged as secretary to Ghadiali while he was delivering lectures in Portland on "spectro-chrome therapy."

On December 4, 1925, Ghadiali was sentenced to five years imprisonment in the Atlanta penitentiary. While he was in the penitentiary, there was an outbreak among the prisoners. Because of his services at that time he was released March 1, 1929. He immediately went back to the spectro-chrome quackery and claimed in his advertising that he was pardoned by the President.

In 1931, Ghadiali was arrested in Cleveland, Ohio, and probably since that time he has been arrested and tried in a good many places. He was found guilty in a suit tried in Brooklyn in 1946 and again recently

in New Jersey. The federal court at Camden, N. J., found him guilty on all twelve counts after a trial of forty-two days. On January 7, 1947, the court fined him \$1,000 on each count, making a total of \$12,000 fine and also one year imprisonment on each of three counts, the prison terms to run consecutively. At the time of suspending part of the penalty, the judge instructed Dinshah Ghadiali to dissociate himself completely from the Spectro-Chrome Institute and Spectro-Chrome Metry. The court indicated that he must make all records available to the government at all times and that he must turn over all his literature, including some 4,000 copies of an encyclopedia, for destruction. The court then suspended the prison sentence and put him on probation for five years, saying that Dinshah is now an old man, 73 years of age, and because of his age, the judge did not deem it advisable to incarcerate him. He did not wish to give Dinshah's followers the morbid satisfaction of regarding Dinshah as a martyr. Dinshah filed an appeal based on the theory that the sentence is inhuman and is in violation of the eighth amendment of the Constitution.

#### SUMMARY

The services rendered by the American Medical Association in its battles against quackery have been widely recognized as one of the most important services in behalf of the people of the United States. The effects of its exposés have been most salutary in preventing quackery and charlatanism which might well have been rampant, at least until the passing of the more recent Pure Food and Drugs Act and the Wheeler-Lea bill.

Week after week down through the years the Association has published its exposés of the charlatans. The evolution of government controls makes it reasonably certain that the future is not likely to see again such charlatans as Albert Abrams, John R. Brinkley and Norman Baker.

(The End)

## THE PRESIDENT'S PAGE

CONNECTICUT physicians by nature are self-reliant.

James Truslow Adams pointed out that the original thirteen colonies had surrendered much of their sovereignty to the new federal government, whereas states which later joined the federation received important rights and privileges. This, he asserted, explains the reluctance of descendants of the original colonies to believe that Washington can do for us as well as we can do for ourselves.

Times have changed and life is no longer simple. On all levels, national, state, and local, we observe an increasing tendency for organized society to arrange and control large areas of our lives. When these extensions of government are sound and in the public interest, we must, as good citizens, exert ourselves to make the operations smooth, efficient and economical.

The veto by President Truman of SB526, The National Science Foundation Bill, emphasizes that the first attempts to set up this much needed undertaking have not been successful. The difficulty appears to be chiefly in deciding who is to control its affairs. This new extension of government into scientific research and development must be wisely established. It will be the task of Congress to develop a National Science Foundation giving maximum protection from the kind of political control feared by all scientific men, without delegating to the Foundation powers involving national defense, which must be under executive control of the President.

There is no place here for pessimism. It is a difficult task, but it can and must be accomplished.

James Raglan Miller, M.D.



# CONNECTICUT STATE MEDICAL JOURNAL

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## EDITORIALS

### The Twenty-Second Clinical Congress

The Clinical Congress of the Connecticut State Medical Society now in its twenty-third year of existence announces its program for the 1947 session on other pages. The comparison of the present program with programs of the earlier years is interesting because it reflects so well the extraordinary changes in diagnostic and therapeutic methods since that time. The introduction of such subjects as psychotherapy in general practice, occupational disease and rooming-in for mothers and infants emphasizes important trends in modern medicine. The entire program is excellent in the wideness of its scope and it presents an opportunity for Connecticut physicians which is self evident. The unparalleled success of the Congress over the years demonstrates the fine spirit of cooperation between the Society and the Yale School of Medicine which is just as it should be. As in previous years it is important to register early in order to save time and insure convenience on arrival at the meeting. Register Now!

### The Practitioner of General Medicine

The establishment of a Section on the General Practice of Medicine by the House of Delegates of the American Medical Association in 1945 was an important step forward. Emphasis by that body on this large and important group of physicians is a proper counteraction to the inauguration by certain hospitals of a policy limiting staff appointments to physicians certified by specialty boards or holding

membership in certain special medical societies. The resolution passed at the last session of the House of Delegates of the Connecticut State Medical Society is also evidence of an unanimity of medical opinion on this question, a part of which reads, "that the criterion of whether a doctor may be a member of a staff or head of a department shall be his actual ability as a doctor, and not dependent on special society or board membership."

That an unwholesome separation of the practitioner of general medicine and the specialist has become even a matter for discussion bodes no good for American Medicine if correction is not made at once. That specialists are physicians first and specialists second are probably trite words, but it is certain that that which concerns medicine concerns every physician, specialist or not. In large measure every physician should consider all medicine as his province in the same spirit that Bacon did all knowledge. The specialist who has interest only in his own field of medicine is pursuing a narrow and unintelligent course which will inevitably result in mental isolation and, finally, stagnation.

As a professional group we must realize that neither by words nor by resolutions can we affect the social status of the practitioner of general medicine. He needs no change in his position, but he does deserve a sincere recognition of what he is and the truly important and essential contribution he has made and is making in our social economy.

One hundred years ago Rudolphe Virchow stated

that "medicine is a social science;" and more recently E. H. Ackernecht has said "Disease and its treatment are only in the abstract purely biological processes. Actually such facts as whether a person gets sick at all, what kind of disease he acquires, and what kind of treatment he receives, depend largely on social factors. Medicine's practical goal is not primarily a biological one, but that of social adjustment in a given society." As an exponent of the idea behind these wise words the practitioner of general medicine stands alone among doctors. When Robert Louis Stevenson wrote his undying eulogy of the physician, he was not thinking of Harley Street but of some William MacLure going his rounds "among the heather." In our own time among our own acquaintance we have all known such men, and in great number they are with us today. If we would seek appraisal of their true worth in society, we would do well to read again the words of Lord Kilspindie, spoken at the grave of his friend: "Friends of Drumtochty, it would not be right that we should part in silence and no man say what is in every heart. We have buried the remains of one that served this Glen with a devotion that has known no reserve, and a kindliness that never failed, for more than forty years. I have seen many brave men in my day, but no man in the trenches of Sebastopol carried himself more knightly than William MacLure. You will never have heard from his lips what I may tell you today, that my father secured for him a valuable post in his younger days, and he preferred to work among his own people; and I wished to do many things for him when he was old, but he would have nothing for himself. He will never be forgotten while one of us lives, and I pray that all doctors everywhere may share his spirit."

### G. B.

We welcome in our pages the occasional guest editorial which we are honored to sign with initials so long familiar in the annals of Connecticut medicine. To our younger members who may not recognize this author we would suggest a query of one of their older colleagues. We salute you, G. B., across the miles of separation. May your pen never lose the charm of its wit and the soundness of its wisdom.

### The Medical Education of the Public

"A little Knowledge is a dangerous thing, drink deep or taste not the Pierian Spring," Pope.

There was a time, not more than a few generations

ago, when the public knew little about the Science and Art of medicine. Indeed, it would be fair to say that for centuries physicians discouraged the dissemination of medical knowledge to the man on the street. We have to go back but a few centuries to reach a period when medical books, even in the English speaking countries, were almost all written in Latin though there were always feeble attempts at popularization in the form of herbals and household medical handbooks written in the language of the common folk.

Now all this is changed, and the public is exposed to a torrential flood of medical information from both tainted and legitimate sources. The most common source of biased and unreliable information has been for generations the patent medicine vendors with their phoney physiology and tarnished therapeutics, and this flux emanates from the press, from circulars distributed with nostrums, and from radio boosters with their succulent superlatives and unctuous urgings. Then there are the half-truths disseminated by the cults and, as Stephen Leacock once suggested, a half-truth is like a half-brick, it carries farther than a whole one.

It is true that many decent newspapers try to keep their advertising pages free from fraudulent claims, and that the best of them employ competent scientists to advise them on medical information printed in their news columns. It is likewise a fact that some radio programs present honestly the claims of the remedies they advertise, even though the language in which they are couched is that of fulsome flattery. Nowadays too the weekly and monthly magazines are apt to contain articles on the more spectacular advances of medicine and many of these are well conceived and clearly presented. It is unfortunate that, at times, information is given out prematurely and that occasionally contributions come from the pens of men who, though trained in science, are more interested in spectacular presentation than in scientific accuracy. One may add to this list the specialized information given out by government bureaus, by organizations such as the anti-tuberculosis and anti-cancer groups, the prenatal and well-baby clinics, the committees on mental hygiene, the medical columnists, the school and visiting nurses, and last, but not least, special radio talks and health magazines like *Hygiea*, sponsored by the representatives of the regular medical profession. It should also be noted that the practitioners of today, in their talks with patients, have adopted a more



realistic and rational viewpoint than formerly prevailed. It has become increasingly obvious that patients who are given an insight into the nature of their illness and the rationale of cure are more apt to cooperate than those left in the dark. Needless to say this must be done tactfully in order to avoid alarming them.

An attempt to assess accurately the value of this popularization to the public is difficult if not impossible. It seems reasonably certain that, by and large, the results are beneficial, but that there are objectionable side-effects cannot be denied. The intelligent and well balanced among the laity usually benefit from the medical information which they acquire. The less intelligent and the neurotic may glean only enough to cause apprehension or even to encourage the development of phobias or other types of psychoneuroses. But even apprehension and phobias are not entirely without benefit when they lead the patient to seek competent advice. Even so there is an unavoidable residuum of neurological morbidity which, in occasional patients, may persist for years.

At all times Medicine is evolving through changing phases of opinion on various subjects and at present one of the most prominent of these is psychosomatic medicine. From the time of Hippocrates physicians have recognized the importance of the influence of the mind on the body; indeed the whole atmosphere of healing centers such as that at Cos tended to emphasize psychological factors. The recent emphasis on psychosomatic medicine has been, in the main, salutary, for there is no question that for generations too little stress had been placed on the psychic aspects of so-called organic diseases. The development of Christian Science was evidence enough that regular physicians were not sufficiently emphasizing these factors. The chief benefit of psychosomatic medicine has been to focus attention on the importance of considering the individual as a whole.

The unfortunate by-product of this development has been the acquisition by many neurotic and psychotic individuals of the language and theories of psychology and psychiatry. Even normal and well balanced individuals frequently rationalize their errors of judgment and among the neurotic the hunt for psychic alibis is a continual one. To put into the hands of such people the jargon of psychology and psychiatry is to furnish them with a means which encourages them "to interpret every trivial thought

and feeling in psychological terms." This particular phase of the medical education of the public presents a difficult problem, and the commonsense solution is, as Burlingame suggests, a return to instruction of the public in the "homely, easily understood, affirmative rules of mental health." All of which does not mean that because of its drawbacks the medical education of the public must be abandoned, but indicates that it must be handled with good judgment, with discrimination, and with tact. For the solution of the problem physicians must, of necessity, be chiefly responsible, but without the cooperation of intelligent and understanding laymen the maximum benefit cannot be obtained.

G. B.

### The Nurse in 1947

The various winds which have been blowing from all directions to fan the nursing problem have now gathered themselves together into a veritable storm. Shorter hours and better pay have been demanded by the nursing profession and are being granted, thus adding to the almost overwhelming cost to be met by the hospital patient today. The American Surgical Association added to the storm by charging that the nursing profession has "lost sight of the need of the sick for adequate nursing care." Irene Carn, R.N., associate chairman of Skidmore College Department of Nursing—New York Postgraduate Medical School and Hospital, informs her profession that it must nurse people better by studying the means of so doing, by expressing and sharing findings, and by taking the time to work together.

Dr. Frank H. Lahey of Boston calls attention to the fact that in 1941 he expressed apprehension over the nursing shortage at that time and now, six years later, sees no immediate prospect of any improvement in the situation. Dr. Lahey calls for an expression of ideas from everyone involved. He opposes the amount of medical instruction given nurses under the present curriculum, believing that few nurses comprehend it, let alone ever will use it. To him it is a waste of the physician's time spending so much time in medical instruction to nurses. Two years of high school is adequate for a service nurse and four years of high school an adequate preliminary education for any nurse. He favors two types of nurse education, one for the service nurse and one for the nurse educator. The motif of personal service is being lost. Any hospital having an inadequate number of nurses should meet its obliga-

tions by organizing a service nursing program "or something comparable to it."

At the annual meeting of the American Nursing Association last winter the Raymond Rich Associates, who had been retained to study the mechanisms of the national nursing organizations, presented a complex report to an unprepared audience. Out of this came the formation of a committee within the Association to study the report and attempt to find a solution to the nursing crisis.

Organized medicine is aware of the urgency of the situation. At the Atlantic City session of the House of Delegates of the American Medical Association the president was empowered to appoint a committee to study this same problem. Dr. Bortz selected as chairman of this new committee the chairman of the Council of the Connecticut State Medical Society, Thomas P. Murdock. An indefatigable worker, Dr. Murdock will bring to the committee in its deliberations the experience of over a quarter of a century in the practice of internal medicine in Meriden and first hand knowledge of the nursing problem as president of the staff of the Meriden Hospital.

### Economic Cost and Significance of Disability

There has been much discussion concerning the economic cost of disability. The prophets of doom would have us scurry to cellars as our present social and economic evolutions grind to a shuddering halt, followed by an immediate and benevolent leveling of socio-economic hills and valleys.

However, this does not belie the fact that a considerable burden rests upon the community, state and nation. Day to day loss of wages by regularly employed workers has been quantitatively estimated at three to four billion dollars per year, exclusive of production and sales loss to industry which may well push the total to ten billion. This total does not consider the additional tangible costs of medical care of disabling illness which has been recently estimated at \$3,712,000,000, nor the many intangible costs to both worker and industry in terms of efficiency, happiness, and the ability to meet every day problems, nor the problems and loss created by illness of housewives, children and the aged.

This immediate and apparent burden is not the only cost. The health and productivity of our work-

ing and professional forces will continue to be ever increasing factors of strategic importance. Not only will personal health be a vital factor, but also will be the health of dependents as it may constitute a financial, physical or mental drain on the health and productivity of the breadwinner.

This is a challenge to the medical profession, and it would be well to define the problem and discuss the methods by which it can be met. Particularly challenging is the problem of disability in our production forces.

Strow, in a monograph of the *Research Council for Economic Security*, points out the confusion that exists in defining disability. Ordinarily the patient, the shop or institution, the physician, or lay compensation commissions may be individually or severally called upon to make that definition. It is obvious that non objective factors will influence the individual or cooperative opinion. Thus, a need exists for objective definition and evaluation of disability. Strow suggests that disability "is physical or mental inability to follow the individual's ordinary pursuits," continuing with the explanation that "in the case of the worker this means incapacity to engage in the present occupation, or if unemployed, to engage in the customary occupation or last one employed in. In the case of other individuals, disability means the incapacity to carry on the individual's functions in the family, the school or the community because of physical or mental condition." This definition implies a broad problem. An attack may be made upon it by use of certain tested methods of reducing disability and its attendant costs. The positive approach is exemplified by the developing field of orthogerasia, or rehabilitation in medicine. We are urged by the exponents of the new Physical Medicine to recognize and utilize the remaining and latent talents of the incapacitated individual, and to do so as early as possible.

The industrial physician is not accused of sadism or lack of concern for his patient when he returns an injured patient to work in short order. Good practice dictates that he begin job retraining for the good of the patient, his family, employer and community, during the period of convalescence.

Disability may exist as the result of developmental anomaly, childhood or adult disease or accident, exclusive of purely compensable injury or illness. The means are at hand for minimizing the human and economic suffering of non occupational



disability. Private and public funds and facilities for reparative care, now within the reach of all, should be brought to the attention of those needing assistance for self or family. Local health officers can advise on these facilities, as can members of the Connecticut Rehabilitation Association, a coordinating agency.

Rehabilitation of compensable disabilities falls to some extent within a certain legal framework. Making due allowance for the human foibles which complicate the resolution of compensable disabilities, fair adjustments are the rule. The physician can enhance the sometimes ponderous machinery of legal adjudication. The disability period and all its associated costs can be diminished by thoughtful and cooperative liaison between family physician and industrial physician. This will not create disregard for the health or welfare of the patient, nor will it deprive him of just, legal recompense for occupational disability. On the contrary it places such matters in proper perspective, emphasizing on many an occasion, the added benefits obtained from rehabilitative care, and rapid, guided return to work.

The physician must play a large part in reducing the tangible and intangible costs of incapacity. He has been criticized, rightly or wrongly, but nonetheless criticized, for ignoring psychological factors and failing to delve into motivation, particularly in cases of compensable nature. Further, he has been charged with lack of knowledge of occupational conditions. Physicians will by choice consider psychological factors and delve into motivation. The industrial physician knows occupational conditions as he discharges his professional responsibility. The growth of occupational medicine and hygiene, the expanding facilities for training in this field, the interest and requests of management and labor lend well to the attacks upon disability and its concomitant costs.

Unfortunately, despite the efficacy of preventive medical and public health measures, upper respiratory infections remain as a major cause of non occupational disability. This should not discourage us, however, from putting into practice every measure available for preventing or reducing temporary or permanent disability. Keeping in mind the significance of disability in our social and economic pattern, every physician will continue with renewed vigor his assault upon needless and prolonged periods of incapacity, whatever the cause.

### Detention of Mentally Ill Persons

At the recent 1947 session of the Connecticut General Assembly, which ended in June, several significant changes were made in the law affecting commitment of the mentally ill, published on page 773 of this issue.

Perhaps the first important change concerns Public Act Number 254 and provides for repeal of 676c of the 1935 supplement entitled "*Detention of Violently Insane Persons.*" This has been retitled "*An Act Concerning the Detention of Mentally Ill Persons.*" This change in terminology is significant of the new approach to the whole problem and is characterized by other changes noted below.

Here are some of the other noteworthy features of the act as revised by the Legislature:

1. Where a person has been admitted into a hospital on an emergency certificate and an application for his commitment has been made to the Probate Court, he may be detained in the hospital beyond the thirty day period until a decision is rendered by the Probate Court as to his mental status. (The new features here is the provision for detention beyond the thirty day period.)

2. The new law does not specifically require that the emergency certificate be sworn to by the physician who issues it. It must, however, contain a description of the patient's mental and physical condition and as much of the history as is known, and must state that the person is in need of immediate care in a hospital for mental illness.

3. Prior to hospitalization the patient has the right to be examined by a physician of his own choice and if such physician concludes from his examination that such person is not mentally ill, such person shall not be admitted to or detained in a hospital for mental illness. (This provision for examination by a physician of one's own choice is new).

4. Except for voluntary admissions, when a patient has been admitted to a private hospital for mental illness the new law provides that the person in charge shall immediately notify the secretary of the public Welfare Council in writing. The said secretary shall also be notified of the discharge of such patient before or at the termination of thirty days, or of the pending or the completed commitment of such patient by a Court of Probate.

5. The new law becomes effective October 1. The rulings affecting the new law will probably be forthcoming from the State Departments.

## The Study of Sterility

Under this title Dr. W. W. Williams discusses some of the general aspects of this important medical and sociological problem. The incidence of involuntary sterile unions has been variously estimated at 13-17 per cent, or one in every eight marriages, and according to one authority there are two million childless couples of childbearing age in the United States. As the author points out, proper sterility studies today necessitate complete medical, endocrine, and genital studies of both partners.

Until comparatively recently the study of sterility has been chiefly directed toward the study of the presumably barren woman. Today, however, the husband is as likely to be at fault as his mate. It is evident, therefore, that we may expect real progress in this field as soon as physicians recognize the routine study of spermatoc pathology as a part of any diagnostic survey of sterility. Dr. Williams' warning against diversification of the recommended technique of uterotubal insufflation should be heeded, for the hazards of the patient are thereby increased, which may lead to medical legal liabilities.

The interest in infertility is rapidly expanding due to an increase in knowledge of the subject and to greater interest on the part of the public and the profession. Among recent important contributions are those of Van Wagenen and Rubin. The former working at the Yale School of Medicine has presented experimental evidence that sperm viability within the genital tract is longer than has been supposed. Working with the rhesus monkey, a fine experimental animal for study in this field owing to the fundamental similarity of its menstrual cycle to that of the human, this author found that 3 of 22 animals conceived after mating on the sixth day of the cycle. An important aspect of this observation is that by analogy the so-called "safe period" is not substantiated, a fact which has been suspected by many physicians from their own clinical experience. Rubin in a recent analysis of 1,000 consecutive cases of infertility concluded that it would be well for all couples to have fertility tests before marriage, or very soon thereafter if they would save themselves the disappointment of a childless marriage. He states that the use of contraceptives by couples who believe themselves to be fertile, but are not, often conceals the need of medical treatment for infertility until too late. He recommends that couples who wish to have children at some later date be examined for potential infertility before they resort to the use

of contraceptives.

The treatment of infertility is being recognized widely as a distinct special field in clinical medicine, as is witnessed by the inauguration of a national clinical society for its study and the number of special clinics which have been established throughout the country.

## Cooperative Internships

The announcement that Columbia University College of Physicians and Surgeons has established an affiliation with Mary Imogene Bassett Hospital at Cooperstown is viewed with interest in Connecticut. Columbia's purpose is to provide training in rural medicine and in small hospital procedure and practice for its medical students who will serve as clinical clerks in the Bassett Hospital. Staff physicians who give instructions will be appointed to appropriate academic positions by the University.

This move by a great metropolitan medical school is reminiscent of a similar proposal made here a number of years ago. It was then suggested that interns serving in some of the larger hospitals in the state be assigned for periods of three or four months in one of the smaller hospitals as part of their training. It appeared that many things would be gained by such a program and Columbia's adoption of the idea is evidence that it does have possibilities.

When considered here it was pointed out that many young physicians settle in small towns and it would be a good thing for them to know the pattern of practice in such areas and the ways of small hospitals. Also if a large and well known hospital permitted its interns to have a part of their service in another hospital it should in good judgment have the privilege of advising in regard to the kind and amount of training its interns would receive and as a result the whole of intern service could be improved. It was further believed that this cooperative arrangement would assure properly qualified small hospitals a supply of good interns and answer a continuous problem for them. Such a plan has been in successful operation in eastern Massachusetts for a time and new consideration of it here could be fruitful.

## The Connecticut Commission on Alcoholism

Studies have shown that the average doctor sees and recognizes in the course of a year's practice a



sizable number of chronic alcoholics. Today it is generally acknowledged that the alcoholic is a sick person involving medical, psychiatric, and social service treatment for his rehabilitation. Because he is sick, he is deserving, therefore, of all the help that can be given, for in a large percentage of instances he can be salvaged. In this issue Drs. Bacon and Miller describe the background and the functioning of the Connecticut Commission on Alcoholism. The part that the medical profession must play in this important program is obviously a major one. Nevertheless, it must be recognized that the rehabilitation of the alcoholic is a long process. The general practitioner has neither the time nor the facilities for treating most of these patients. The program set forth by the Commission therefore is welcomed as a means of dealing with this problem, in which the cooperation of the physician can be of great assistance. Haggard states the position in this way: "The practitioner without special training cannot usually be expected to treat the alcohol habit competently, nor would he, as a rule, wish to attempt this treatment. But nevertheless the part he can play toward the success or failure of eventual recovery of the alcoholic is often the crucial part. It is the attitude and the advice—but particularly the attitude—of the physician to whom the alcoholic and his family comes first that in great measure determines the course which the alcoholic will follow and also the understanding and cooperation—or lack of them—which he and his family will show."

### Correction

In the July issue of the *CONNECTICUT STATE MEDICAL JOURNAL* an editorial entitled "The Rising Hospital Costs" quoted Dr. Frank A. Weiser to the effect that "a more efficient method (of aid to hospitals) would be to free donations, to accredited hospitals, of the gift tax and permit their deduction from the income tax." This statement seems to have created some misunderstanding among our readers.

Dr. Weiser was probably referring to the overall cost picture. Gifts to exempt institutions such as the Hartford Hospital are totally exempt from the Federal Gift Tax, the Federal Estate Tax, and the Connecticut State Succession Tax. There is no Connecticut State Income Tax. The Federal Government thus does encourage gifts to hospitals and other charitable organizations by making the entire

gift exempt from the gift tax and the estate tax and it further encourages such gifts by making them exempt from the income tax up to 15 per cent of one's annual adjusted gross income.

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### War Neuroses

Brigadier General William C. Menniger, MC-AUS, speaking at the Graduate Fortnight of the New York Academy of Medicine in October 1945, remarked that one might generalize by saying that if the patient has made an attempt to fit into his civilian situation and is consciously aware of his symptoms, is preoccupied with his traumatic experiences in the Army, has recurring disturbing dreams, the chances are that he should see a psychiatrist. In the Army, we have found that psychotherapy under sedation is a valuable short-cut to relieve the pent-up emotion. Hypnosis has also proven to be an effective therapeutic tool for this purpose. In both of these types of treatment, the ultimate success depends upon the skill and the knowledge of the psychotherapist.

On the other hand, if the patient is exhibiting minor evidences of anxiety in the form of restlessness, minor physical complaints or problems of adjustment to the people around him, it is very likely that the general practitioner can and should help meet these problems. In so doing, he needs to appreciate that sometimes he can help directly by merely being a good listener and pointing out the inconsistencies, the discrepancies in the man's thinking and feeling processes. Very often he can make positive suggestions with regard to the manipulation of the environment. If one could insure sufficient family affection, economic and social security, easily accessible ego gratifications and good physical health, many of these veterans would be helped if not entirely rehabilitated.

When one takes into consideration the fact that 315,000 soldiers have been discharged from the Army for neuropsychiatric reasons, he may grasp the importance of this problem as a postwar challenge to medicine. It is to be hoped that all physicians will prepare themselves to accept and to treat what the Army medical officers discovered were among their biggest problems—the emotional factors in the production of illness.

## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

### EXECUTIVE COMMITTEE OF THE COUNCIL

The Executive Committee of the Council, consisting of Dr. Miller, Dr. Murdock, Dr. Harvey and the Secretary, met for the transaction of general business on Wednesday, July 23.

### THE ADVISORY COMMITTEE TO THE PUBLIC WELFARE DEPARTMENT

The Advisory Committee to the Public Welfare Department met in the offices of the Society on Thursday, July 24, for the discussion of the revision of professional fees for old-age assistance cases. There were present, Dr. Miller, Chairman; Dr. Leonard Parente, formerly Medical Advisor to the State Department of Welfare and now Health Officer for the Town of Hamden; Dr. Samuel B. Rentsch, Chairman of the Society's Committee on Medical Care of Veterans; and Dr. Alfred Labensky, Dr. Theodore S. Evans and Dr. Chris Neuswanger.

#### Measures Relating to Social Welfare Enacted by the 1947 General Assembly

##### STUDIES AND COMMISSIONS

HB2—Setting up an eight-member, bi-partisan fair rent commission and authorizing the employment of a state rent coordinator; providing for the establishment, in each town and municipality, of a fair rent board of three members; said board to prevent unreasonable increases in rents (no increase to be over 15 per cent); to determine the types of housing accommodations to which the act shall apply, to provide for the making of adjustments in cases in which the maximum rent is substantially higher or lower than the prevailing rents in the same area or in which substantial hardship has resulted from increases in taxes or other costs, and to prescribe the conditions under which evictions may be allowed. \$50,000 appropriated to carry out its purposes. Act to take effect March 1, 1948.

HB35—Instructing the State Personnel Director with a committee of five superintendents of State institutions (to be appointed by the Personnel Board) to make a study of maintenance charges to employees in State institutions and to recommend changes looking to removal of existing inequities.

JHR288—Instructing the Legislative Council to investigate and consider the problem of so-called

psychopathic personalities and report with recommendations to next General Assembly.

HB442—Providing for a study by the Public Welfare Council of rates of payment for treatment and care in State institutions.

HB1447—Setting up a seven-member commission to direct a program of building for the humane and welfare institutions. (Will expend six to seven million appropriated to State institutions for the mentally ill.) Dr. Joseph H. Howard and Dr. Joseph I. Linde have been appointed members of this Commission.

SB819—Empowering the Public Welfare Council, the Judges of the Juvenile Court and the Commissioner of Welfare to appoint a Juvenile Welfare Committee consisting of a member of the Public Welfare Council, a Judge of the Juvenile Court, the Commissioner of Welfare, and not more than six citizens. The Committee shall study the causes of juvenile delinquency and child neglect and shall formulate plans for putting into effect the recommendations of the Robinson Study on delinquency and child neglect. Committee to receive *no* compensation, travel or other expenses.

SB823—Directing the Legislative Council to examine the County Jail system with special reference to the possibilities of closer collaboration with the Commission on Alcoholism; establishment of farm and



industrial art work programs for jail inmates; clarification of the respective spheres of responsibility of the county sheriffs and the county commissioners; consolidation of any of the several county jails and/or their relocation to rural areas within their respective counties; the institution of a State Jail Farm; to report its findings with recommendations to the next session of the General Assembly.

SB824—Instructing the Legislative Council to re-examine the legislative changes recommended in the report of the Legislative Committee appointed by the special session of 1946 to study the State mental institutions; to study the accumulated data and reports now on file concerning these institutions; to visit and study the institutions first-hand with special reference to sanitary and safety conditions of buildings and to adequacy of treatment, facilities of personnel, and of salary scales; and to report its recommendations, together with any proposed legislation, to the 1949 General Assembly.

#### CARE AND TREATMENT OF INEBRIATES

HB32—Changing the name of the Board of Trustees of the State Fund for Inebriates to Commission on Alcoholism. Dr. Charles T. Bingham is a member of this Commission.

HB133—Authorizing the Commission on Alcoholism to determine the commitment, support and treatment costs of persons committed to the Commission or to any inebriate asylum maintained by the Commission; and to secure reimbursement in accordance with provisions of the law relating to the commitment and support of mentally ill persons in State hospitals. Funds so collected by the Commission to be deposited with the State Treasurer.

SB814—Providing that persons liable for the support of an indigent narcotic addict shall pay \$8 weekly (instead of \$5) for such addict's care in a State hospital. (Rate for paupers, whose care is chargeable to town of legal residence, remains at \$5.)

#### MEASURES AFFECTING CHILDREN

HB189—Appropriating \$135,000 to the American School for the Deaf for additions, alterations and sanitary facilities.

HB373—Providing that application for admission to the Newington Home for Crippled Children shall be made to the State Commissioner of Welfare (rather than to the Probate Court).

HB401—Providing for State support, up to two-thirds, of the cost of a program of education, ap-

proved by the State Board of Education, at Newington Home for Crippled Children, but support shall not exceed \$200 per pupil per year.

HB724—Authorizing the Commissioner of Welfare to place neglected and uncared-for children who are wards of the State in homes outside the State (as well as within the State).

HB853—Giving to children born in institutions where their mothers are confined at the time of their birth, residence in the county where the mother was living at the time of her admission to the institution.

HB854—Providing for uniform notices to the Commissioner of Welfare on all commitments throughout the State.

HB919—Prohibiting the employment of children under 14 years of age in any form of agriculture where 15 or more persons are employed. Limiting employment of 14- and 15-year-olds to 48 hours per week and requiring them to obtain birth certificates or work permits. Setting up a commission in the Department of Agriculture to administer the provisions of the act.

HB1356—Raising the weekly board rate at the House of the Good Shepherd from \$6.50 to \$7.50.

SB262—Prohibiting the attendance of children under 14 years at any time at certain places of amusement without being accompanied by proper adult person; permitting children to attend roller skating rinks, theatres, moving picture shows prior to 6:00 P. M. without parents or guardians.

SB513—Amending Section 324f (1941) to separate civil and criminal action on fraud under Aid to Dependent Children.

SB652—Providing that persons legally liable for support of children shall reimburse the State for assistance granted under Aid to Dependent Children if and when they become financially able to do so.

#### PROGRAM FOR THE CHRONICALLY ILL AND AGED

HB962—Appropriating \$600,000 for the establishment of a central institution for the study of chronic disease.

HB963—\$200,000 for grants in aid to State-aided hospitals for the care of the chronically ill and aged.

HB965—\$100,000 for grants in aid to municipal hospitals and county institutions for the care of the chronically ill and aged.

HB741—\$20,000 for next biennium for continuing the work of the Commission on the Chronically Ill and Aged. Dr. A. Nowell Creadick is chairman of

this Commission and Dr. Joseph H. Howard a member of it.

#### OLD AGE ASSISTANCE

SB647—Making provision for the foreclosure of existing liens and for the sale of such property by the Commissioner of Welfare after foreclosure and giving him discretionary power in permitting a surviving spouse to remain on property during his life.

SB650—Securing the claim of the State property of old age beneficiary upon discontinuance of award so that property cannot be disposed of without knowledge and consent of Commissioner of Welfare.

HB674—Raising the maximum old age award from \$40 to \$45 monthly.

HB866—Excluding payment by the State of funeral expenses of a deceased beneficiary having sufficient life insurance coverage.

#### DIVORCES TO BE REPORTED

HB34—Provides that the clerks of the Superior Court shall report all divorces and facts relating to them to the State Department of Health which shall supply forms for such purpose (looking to more detailed study of the problem of divorce).

#### STATE INSTITUTIONS AND AGENCIES

HB581—Providing that hospitals receiving State aid shall be paid at the rate of \$7 per day (instead of \$4) for the care of any patient when such expense is to be paid from State funds, either directly, or through the agency of any town or organization.

HB587—Increasing the rate of payment to \$7 per day to State-aided hospitals for care and treatment of dependent children, veterans, and Soldiers, Sailors and Marine Fund cases.

HB1297 and HB1298—Providing that any inmate of Southbury or Mansfield Training School who is out on working parole and who is recalled for physical and mental check-up, shall not be billed by the town where he has settlement, for his support at the training school, providing the recalled period does not exceed ten days.

HB1299—Changing the boarding-out law of the State Mental Hospitals to include the State Mental Training Schools.

HB1493—Appropriating \$6,000,000 to \$7,000,000 for capital improvements and equipment at the five State mental institutions.

SB44—Authorizing indeterminate commitments to the Connecticut Reformatory and to permit the

sentencing of offenders between the ages of 16 and 25 to the State Prison for offences for which the minimum term exceeds five years. Repealing Section 378g (1943) which permitted the transfer of inmates of county jails to the Reformatory.

SB722—Reconstituting the Joint Committee of the State Mental Hospitals to permit the State Mental Training Schools to join the Committee if they so desire.

SB723—Legalizing the Joint Committee of the two State Mental Training Schools.

SB802—Codifying the statutes on transfer of inmates of penal and correctional institutions to State Mental Hospitals. Eliminates, in each case, the provision which, under the old law, required that if an inmate of any penal or correctional institution should become mentally ill, the superintendent should refer the matter to the Governor who, in turn, would appoint a commission to examine the ill person and report back to him. Provides *now* that in such a case, the superintendent shall have authority to immediately cause the mentally ill person to be examined by two physicians, one a qualified psychiatrist if available and, in the event that mental illness is found to be present, shall arrange for his transfer.

Repeals sections 1752, 1753, 1841, 1842, 1995, 1996, (all 1930), 785c, (1935), 407g, 408g, (1943) and 399h to 402h inclusive (1945).

Sen. Res. 195—Raising the basic rate of payment at the State mental institutions from \$5 to \$8 weekly.

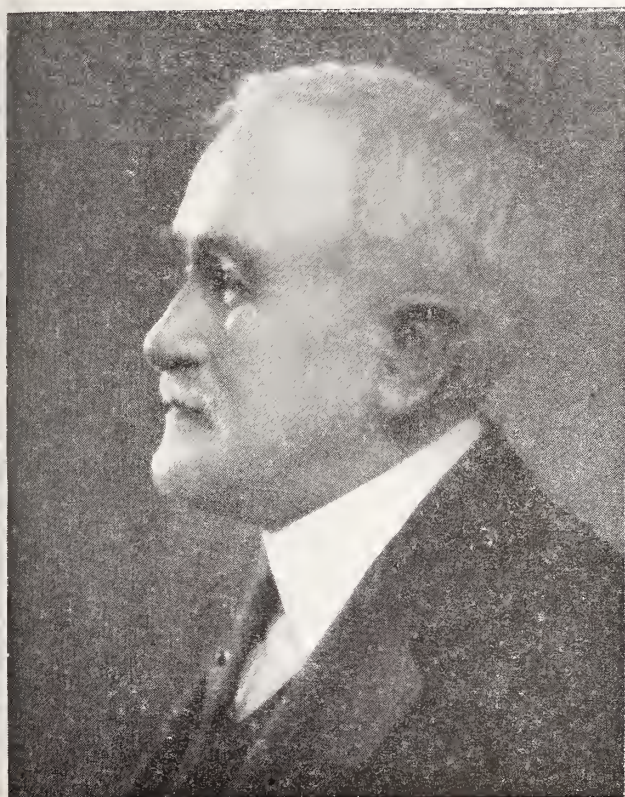
HB1295—Providing for the deportation of indigent persons (as well as paupers); stipulates particularly that any person who has been admitted to any State institution as an indigent or pauper may be deported to the state or country of his legal settlement.

### Our New Exchange Publication

Following a personal interview with Michael Fletcher, one of the directors of *The Practitioner* we are pleased to add to our list of exchange publications this esteemed British medical publication of over 150 years of age. The July issue contains several excellent articles on obstetrics. It also carries an interesting account of the American Medical Association centenary at Atlantic City as observed by our British visitor. We welcome this new exchange.



## Meriden Citizens Present Gift to Building Fund



EDWARD T. BRADSTREET, M.D.

A gift of two thousand dollars, given by residents of Meriden in memory of Dr. Edward T. Bradstreet, for many years one of the leading physicians of that city, has been announced by the Board of Trustees for the Society's Building Fund.

The fourth memorial presentation to be received by the trustees, the gift in memory of Dr. Bradstreet recalls a long and active career in Connecticut medicine. A descendant of the early colonial governors, Thomas Dudley and Simon Bradstreet, he was born in Thomaston, February 15, 1852. His maternal grandfather was Seth Thomas, for whom Thomaston was named.

Dr. Bradstreet received his early education at Thomaston Academy, and graduated from Yale University in 1874. He was married in 1875 to Alice E. Pierce, daughter of Hiram and Sarah (Beers) Pierce of Thomaston. Resolved to seek his career in medicine, he studied at the College of Physicians and Surgeons, Columbia University, and received his medical degree there in 1877. Following a brief

period of postgraduate study, he came to Meriden in the same year and began the lifelong practice which brought him the enduring respect of physicians and his fellow townsmen.

Modest and unassuming by nature, he nevertheless attracted the early attention of leaders in medicine and civic affairs. His counsel was frequently sought and highly valued.

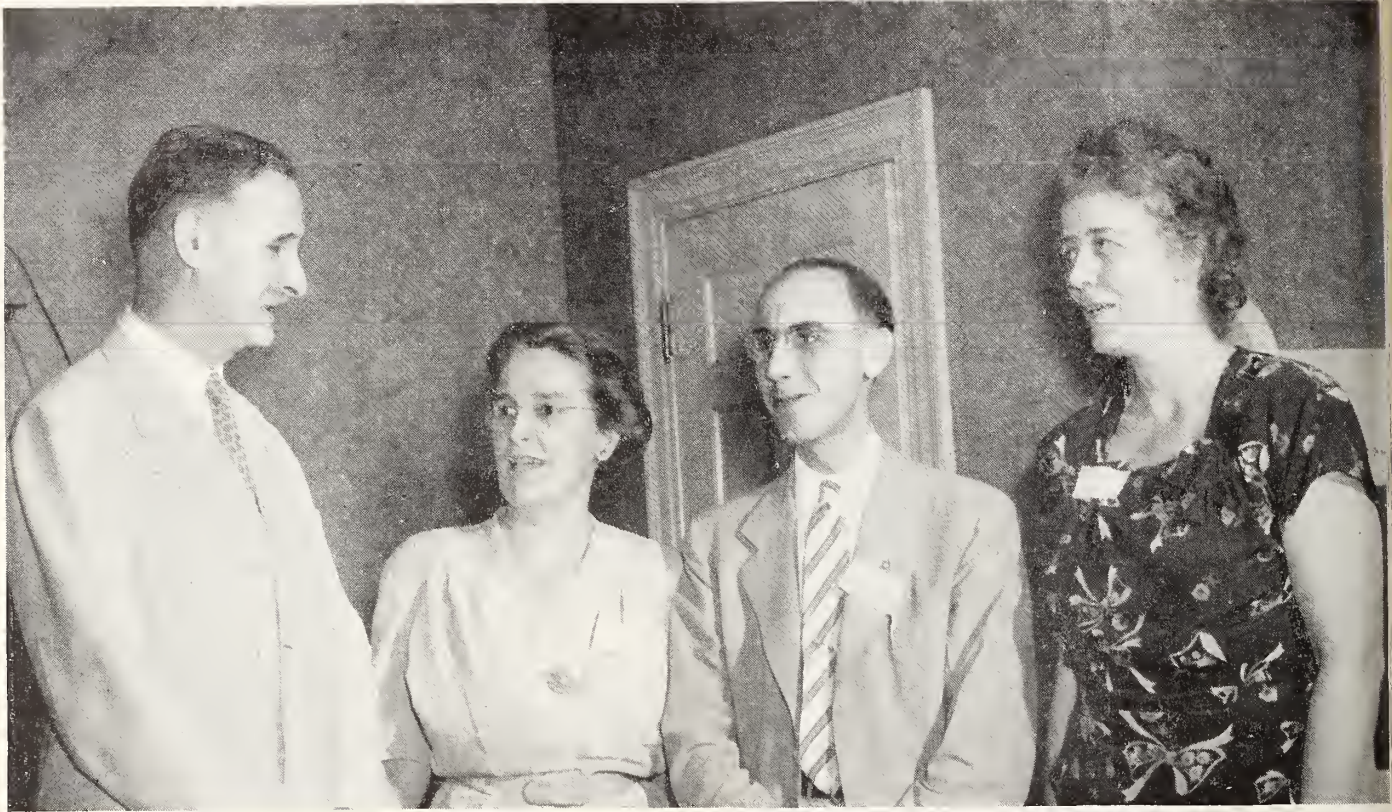
Soon after coming to Meriden, he was called upon to take a leading part in the organization of Meriden Hospital, where he served as a member of the medical staff, and later as president of the medical board, until ill health forced his retirement in 1926. Constantly active in medical affairs, Dr. Bradstreet was one of the early presidents of the Meriden Medical Society, a prominent speaker at meetings of the New Haven County Medical Association and the State Medical Society, and a staunch member of the American Medical Association.

From 1901 until his death in 1931 he served as medical examiner for the Town of Meriden. He was one of the organizers of the Public Health and Visiting Nurse Association of Meriden and the Meriden Tuberculosis Association, and for many years was an attending physician at the Connecticut School for Boys. The establishment of Undercliff Sanatorium was another endeavor to which he gave much of his time and effort. His response to the needs of the unfortunate was evidenced by his untiring efforts in their behalf as president of the Connecticut State Conference of Charities and Correction.

For a considerable period he was one of the directors of Gaylord Farm Sanatorium, and from 1882 to 1893 he served as a member of the New Haven Board of Examiners for Pensions. His continuing interest in university affairs brought him a long term as president of the Meriden Yale Alumni Association, and in civic affairs he became an active member of the Chamber of Commerce and the Rotary Club. In addition to his community medical practice, he was medical examiner for fourteen leading life insurance companies. His many responsibilities did not preclude his interest in wholesome recreation, and when the Meriden Golf Club was organized he became its first president, a position which he held for a number of years. He was a member of the First Congregational Church and the Governor Thomas Dudley Family Association.



## CONNECTICUT'S FIRST RURAL HEALTH CONFERENCE



Dr. James R. Miller, left, president of the State Medical Society, discusses the program at Connecticut's first Rural Health Conference with, left to right, Mrs. Ruth R. Clark, of the University of Connecticut Extension Service, Dr. Norman H. Gardner, chairman of the Society's Committee on Rural Medical Service, and Mrs. John J. Whitehead, of the Parent-Teacher Association of Connecticut.

CONNECTICUT's first Conference on Rural Health was held at the University of Connecticut on July 16.

Arranged by the State Medical Society and the Extension Service of the University, the conference was attended by 123 representatives of civic, farm, educational, and health agencies.

During the morning session the results of a study recently completed by the Society's Committee on Rural Medical Service, headed by Dr. Norman H. Gardner of East Hampton, were announced. The findings were presented by Dr. Creighton Barker, executive secretary of the Society, who pointed out that the sampling of opinions among rural residents indicated that many people in these areas feel that hospital facilities are inadequate, that provisions for the care of the chronically ill are an urgent necessity, and that clinical facilities, except for school dental services, are inadequate in the smaller communities.

The survey indicated that rural residents enthusiastically support the expansion of Blue Cross

hospital care plans in smaller communities, and generally approve the district health plan. Other opinions brought to light a general feeling among rural residents that medical costs, though high, have not outrun other necessary costs of living.

Speaking during the morning program, Albert N. Jorgensen, president of the University, emphasized that education should develop individuals who can see the social problems of the present day, visualize solutions to these problems, and generate the spirit to solve them.

Dr. James A. Dolce, chief of the division of local health administration of the State Department of Health, explained the operation of the district health system. Tracing the development of the district health plan passed at the last session of the General Assembly, he pointed out that two or more neighboring towns are now authorized to form a district for the operation of fulltime public health services. He urged those attending the conference to organize their communities for establishment of such public health districts, and declared that "only with the



machinery of public health will it be possible to improve rural health in Connecticut."

Facilities available for the improvement of rural health through the State Department of Education were outlined by Finis E. Engleman, deputy commissioner of education. Robert J. Smith, commissioner of the State Department of Welfare, said that approximately 25 per cent of the department's annual appropriation of \$33,000,000 will be spent for health services, hospitalization, and medical care.

Dr. James R. Miller, president of the Society, was chairman for the morning program. Other facilities available through state and non official agencies were explained by Dr. Paul S. Phelps, for the State Tuberculosis Commission; Dr. Cole B. Gibson, Connecticut Tuberculosis Association; Dr. Donald B. Wells, Connecticut Cancer Society; and Marion H. Douglass, director of the Hartford Visiting Nurse Association.

Under the leadership of Dr. Norman H. Gardner, the afternoon session was devoted to section meetings on sanitation and housing, communicable disease control, school health, chronic diseases, mental health, and problems of dental health in rural areas.

Some of the conclusions reached by the sections were as follows:

School Health: "As health is an objective of education, health training should begin in the teachers' training schools." Chronic Diseases: "Treatment of chronic illnesses must be considered as inseparable from general medical care. Objective must be rehabilitation aimed toward self-support. There should be a custodial care program for children

who cannot be rehabilitated to the point of returning to society." Dental Health: "Administration of rural dental programs should be on a local level. Advantage should be taken of subsidies for rural dentists as these become available. The education of parents is more important than the education of children in developing dental services in the schools."

Communicable Diseases: "Immunization programs for pre-school children should be promoted by PTA groups, with cooperation of public health councils and town officials. Private and community water supplies should be constantly tested in smaller communities." Mental Health: "The public should assume greater responsibility to learn about these facilities, and professional groups should be responsible for making these facilities known. Funds are now available for the necessary increase in mental hygiene services, but lack of qualified personnel holds up this expansion." Sanitation and Housing: "One half of rural homes have no bathing facilities, one-third no running water. School sanitation is poor educational factor when homes are unsanitary. Fulltime health districts are very desirable to remedy these problems. Public opinion is important and education is vital to insure that the program is carried through."

In summarizing the results of the panel discussions, Professor Ira V. Hiscock, chairman of the Department of Public Health at Yale University School of Medicine, declared that Connecticut has many potentialities for good health services in its rural communities, but that considerable organization and coordination is required to bring them into full effectiveness.

THE INTERNATIONAL PEDIATRIC CONGRESS

THE Fifth International Pediatric Congress was held in New York July 14-17, 1947. The *New York Herald Tribune* in an editorial called it "A Unique World Congress" because it "acknowledges no political divisions, recognizes no conflicting spheres of influence."

Henry Helmholz, M.D., its president, and a sponsoring committee from the American Academy of Pediatrics, The American Medical Association, The American Pediatric Society, The Society for Pediatric Research, and the United States Children's Bureau were responsible for the meeting. A national

program committee, finance committee and committee on exhibits were established. The committee on local arrangements was ably headed by Dr. Miner C. Hill and to him and his committee must go a tremendous amount of credit for the work they did toward making the meeting a success.

Without a question it was the largest and most informative pediatric meeting ever held. There were pediatricians from 56 countries—China, the Philippines, Java, Russia, Sweden, Denmark, England, to name a few. The total registration for the meeting was 2,177, exclusive of student nurses and interns

who visited one session. The United States was represented by 1,670, Canada by 41, and foreign countries by 466. The most outstanding characteristic was the friendly atmosphere exhibited everywhere. Due credit must be given the ladies' committee for the numbers of opportunities they gave those attending to meet each other in a friendly atmosphere and aiding as an information bureau.

There were three main aspects of the Congress. First, the papers were given in four languages—English, French, German and Spanish. A short wave radio system permitted each listener to select the language of his choice by means of earphones. This enabled anyone to listen successfully to the papers. Practically all the papers were delivered by outstanding pediatricians from foreign countries. These papers gave us the child care activities in these various foreign lands.

The second phase was the Scientific Exhibits, 153 in all, grouped as nearly as possible according to the subject. Great interest was shown in this phase of the meeting. The exhibits creating the most interest were endocrine disorders, those on various blood discrasias, penicillin and streptomycin, heart. In fact, all these scientific exhibits were of the highest

qualities. They were for the most part contributed by pediatricians in this country.

The third phase consisted of pre-meeting and post-meeting tours to various medical centers such as Johns Hopkins, Yale, Boston, Chicago, and others. Many of the tours were conducted by commercial firms such as Lederle, Walker Gordon, etc., designed to show their part in medical research.

The official delegates elected Professor Guido Fanconi of Switzerland president of the Sixth International Congress. This meeting will be held in Zurich, Switzerland in 1950.

Peripateticus

## Massachusetts

The Massachusetts Medical Society suffered the loss recently by death of one of its oldest members, Walter P. Bowers of Clinton. For over 25 years Dr. Bowers was editor of *The New England Journal of Medicine* and for many years he was a member of the Massachusetts Board of Registration. Dr. Bowers was a practicing physician for 68 years and the founder of the Clinton Hospital in 1889.

# THESE GAVE

## CONTRIBUTORS TO THE BUILDING FUND — JULY 10 TO AUGUST 10, 1947

### FAIRFIELD COUNTY

Alpert, Max, Bridgeport  
Bogin, Maxwell, Bridgeport  
Felding, Howard A., Stamford  
Grimm, Homer W., Fairfield  
Marglis, Ben, Bridgeport  
McMahon, William H., Jr., So. Norwalk  
Meshken, Jacob, Bridgeport  
Poczabut, John S., Stamford  
Ribner, Harold, Bridgeport  
Sabia, Daniel J., Stamford  
Schopick, Louis E., Bridgeport  
Sheiman, Milton, Bridgeport  
Sheiman, Samuel C., Bridgeport  
Smith, Leo M., Stamford  
Williams, Francis P. A., Monroe  
Zielinski, John B., Bridgeport

### LITCHFIELD COUNTY

Greiner, George, Kent  
Levy, Aaron, Winsted  
Orlowski, Andrew W., Torrington

### HARTFORD COUNTY

Bloom, David I., Thompsonville  
Climan, Max, Hartford  
Crosby, Edward H., Hartford  
Goldstein, Max R., Hartford  
Greenblat, H., New Britain  
Gurwitz, Jack, Newington  
Levine, Howard, New Britain  
Lundborg, Francis L., West Hartford  
Martin, Stevens J., Hartford  
Rogers, Frederic P., West Hartford  
Romaniello, Rocco J., Elmwood  
Sayers, John J., Hartford  
Whitcomb, Benjamin B., Hartford

### WINDHAM COUNTY

Baker, Conrad S., Willimantic  
Chartier, Gerard M., Danielson  
Dinolt, Robert, Putnam  
Maurer, William S., Willimantic

### MIDDLESEX COUNTY

Yerbury, Edgar M., Middletown

### NEW HAVEN COUNTY

Beauchamp, Maurice F., New Haven  
Berman, Harry L., New Haven  
Claiborn, Louie N., New Haven  
Clarke, Clement C., New Haven  
Fabricant, Samuel E., Waterbury  
Friedman, Irving, New Haven  
Huss, John H., Meriden  
Petrillo, Charles, New Haven  
Ryan, Allan J., Meriden  
Taffel, Max, New Haven  
Thorne, Lewis, New Haven  
Wilson, William R., New Haven

### NEW LONDON COUNTY

McLaughlin, John H., Jewett City  
Rapp, Albert G., New London  
Tombari, S. Paul, Waterford  
Woodward, Joseph, New London

### TOLLAND COUNTY

Flaherty, John E., Rockville  
Squillante, O. John, Rockville



## Dr. Thoms Appointed Professor at Yale

Herbert Thoms, associate professor of obstetrics and gynecology, Yale University School of Medicine, and literary editor of the *CONNECTICUT STATE MEDICAL JOURNAL*, has been appointed professor and chairman of the department at the School of Medicine. Dr. Thoms graduated from Yale University Medical School in 1910 and studied at Johns Hopkins Hospital, 1914-1915. He became an assistant in obstetrics and gynecology in 1915, an assistant in pathology, 1916-17, and an associate clinical professor of obstetrics and gynecology 1925-1927, when he became associate professor. He has also served as curator of the Yale Medical Memorabilia and has been an associate in obstetrics and gynecology at Grace-New Haven Community Hospital University service.

## Dr. Murdock Heads New AMA Committee



Dr. Thomas P. Murdock, of Meriden, chairman of the Society's governing council, heads the new five member committee of the American Medical Association appointed to study the nation's problems of nursing care.

Requested by Dr. Edward L. Bortz, AMA president, the committee was appointed by the House of Delegates at the organization's centennial in Atlantic City last June.

Named to serve on the committee with Dr. Murdock are Brigadier General Warren V. Draper, assistant director of the United States Public Health Service; Dr. Donald C. Smeltzer, Philadelphia, formerly president of the American Hospital Association; Dr. Lester R. Dragstedt, Chicago surgeon and member of the American Surgical Association's

Committee to Study Nursing Problems; and Dr. Wingate Johnson, professor of medicine at Bowman-Gray Medical College, Winston-Salem, N. C.

Dr. Murdock has explained that the committee plans to devote a year to the study of nursing problems, and to report its findings to the annual meeting of the AMA in 1948. It will be the first comprehensive study of nursing ever undertaken by the medical profession, and will include all fields of nursing activity, schooling, training, duty, and retirement.

Use will be made of the records of the AMA Bureau of Medical Research to study the economic factors of nursing, including earning capacity, hours of work, retirement funds, the number of nurses available, and the number of new nurses being trained.

In its study of the requirements for admission to schools, the committee will call upon the experience of nationally known educators. It will also ascertain the number of graduates expected during the next few years. Through the National Association of Manufacturers, the committee will seek to establish the number of nurses employed in industry and the number which will be required by expanding industrial health programs in the immediate future.

The committee also plans to interview the Surgeons General of the Army, Navy, Veterans Administration, and the United States Public Health Service to discover the number of nurses now enrolled in these services and the probable number needed during the next several years. Before the committee's work is completed, it plans to conduct a survey aimed at the possibility of instituting a retirement plan for nurses, and to study means of raising their economic status. Though considered highly important by the committee, this will necessarily be a secondary activity. Its initial efforts are being directed toward finding an answer to the problem of what can be done to remedy the existing shortage of nurses throughout the country.

## Dr. J. G. Irving New Aetna Medical Director

J. Grant Irving, M.D., has been promoted from associate medical director to medical director of the Aetna Life Insurance Company. Dr. Irving succeeds the late Dr. Donald B. Cragin. He took his medical degree at the University of Toronto, and after serving as house physician at Toronto General Hos-

pital, continued postgraduate studies at Edinburgh University, Scotland, where he received the degree of Fellow of the Royal College of Surgeons.

After being house surgeon at the Warwickshire Hospital in Coventry, England, and also a member of the staff of Columbia University Medical School, New York, Dr. Irving joined Aetna Life in December 1935 as assistant medical director. He was promoted to associate medical director in 1942.

During the war he served three and one half years with the neuro-surgical service of the U. S. Army Medical Corps in this country, England, and north-west Europe and retired with the rank of Major.

Dr. Irving is a member of the Hartford Medical Society, the Hartford County Medical Association, the Connecticut State Medical Society, American Medical Association and the Association of Military Surgeons of the United States.

### **Lieut. Col. Rogers Awarded Citation**

In recognition of his services in controlling the spread of typhus fever in Italy, Lieutenant Colonel Robert P. Rogers, MC-AUS, of Greenwich, has been awarded the United States of America Typhus Commission Medal.

The citation mentions the meritorious service which he performed with the Typhus Commission during the epidemic at Naples and in southern Italy in the winter of 1943-1944. On duty with the Allied Control Council, he was assigned to the Commission for the duration of the emergency, and was placed in charge of the immunization section. Through his efficient management of this section, Lieutenant Colonel Rogers contributed to the success of the typhus control program.

A graduate of Harvard Medical School in 1925, Dr. Rogers entered the military service in 1942. He is a member of the medical staff at Greenwich Hospital, and has practiced in Connecticut since 1929. A diplomate of the American Board of Pediatrics, he is a member of local and state medical societies, the American Academy of Pediatrics, and the New York Academy of Medicine.

### **Dr. Sokal C. O. of 118th Medical Battalion**

Dr. Joseph E. Sokal, assistant resident in medicine, New Haven Hospital, has been named commanding officer of the 118th Medical Battalion, 43rd Infantry Division, Connecticut National Guard. He holds the rank of Major.

His appointment was recently announced by Major General Kenneth F. Kramer, division commander. Born in Poland in 1917, Dr. Sokal came to the United States at the age of seven. He graduated from Columbia University in 1936, and received his medical degree at Yale University School of Medicine in 1940.

His military career includes service with the famed "Fighting 69th" Regiment of the 27th Infantry Division in the Pacific. A veteran of two beach-heads, Makin and Saipan Islands, Major Sokal also served with occupation forces in Japan as a regimental surgeon in the 11th Airborne Division.

### **Dr. Chaffee Honored in Hospital Building**

At a meeting of the trustees of the Sharon Hospital held July 5, a resolution was unanimously adopted expressing the appreciation of the board of Dr. Jerome Stuart Chaffee's vision in establishing the Sharon Hospital, and his long and untiring labor in managing it.

The resolution provides that a plaque expressing this appreciation be placed in the main entrance of the hospital, and that the original building, in which will be the main entrance, shall be named "Chaffee Pavillion."

The Board believes that this action not only expresses the sentiment of the trustees, but also the appreciation that has been felt by members of the community and of neighboring communities which have benefitted from the excellent service which the hospital has rendered during the past 38 years.

### **Connecticut on Pharmacopoeia Revision Committee**

Two Connecticut men have been selected for the Revision Committee of the U. S. Pharmacopoeia, William T. Salter, M.D., and John Dugan, Ph.G. Dr. Salter, professor of pharmacology at Yale University School of Medicine, is a leading authority in this field and has been active in the work of the Joint Conference Committee of Physicians and Pharmacists in Connecticut. He will be one of twenty physicians to serve in the revision of the U. S. Pharmacopoeia.

John Dugan, secretary and professional director of the Taft Pharmacy, New Haven, is the first pharmacist from Connecticut to be honored by being selected to serve in the revision. Mr. Dugan has been assigned to the scope and ointments, cerates



and miscellaneous galenicals subcommittees as part of the work in pharmaceutical research and in making preparations for the ensuing revision.

## Middletown State Hospital Elections

Dr. George N. Dutcher of Middletown was recently reelected chairman of the Board of Trustees at Connecticut State Hospital, according to an announcement by Dr. Edgar C. Yerbury, superintendent.

Fred N. Smith, editor of the *Middletown Press*, and a trustee for the past two years, was elected vice-chairman, and Mrs. Alice Patterson Merritt of Hartford was named secretary. Elected to the executive committee were Dr. Jesse M. Fisher, Portland, and Theodore Raczka, Middletown attorney.

The consulting staff for the hospital has been approved by the trustees as follows: Carl C. Harvey and Louis O. LaBella, general surgery; A. N. Sweet and Walter N. Nelson, orthopedics; Carl C. Chase and William Joyce, otolaryngology and ophthalmology; H. C. Knight, genito-urinary; G. M. Craig, gynecology; Joseph Magnano, anesthesiology; Harold Speight and F. E. Tracy, internists; William B. Scoville and Benjamin B. Whitcomb, neurosurgery; Cole B. Gibson, diseases of the chest; and Chester Waterman, psychiatry.

## Research Program at Middletown State Hospital

Connecticut, in cooperation with Yale University, is embarking on an organized research program in mental illness that may lead to new developments in the causes of mental illness and its treatment, Dr. Edgar C. Yerbury, superintendent of the Connecticut State Hospital here, announced recently.

Dr. Paul I. Yakovlev of Waverly, Massachusetts, who is well known in medical circles for his research in epilepsy and brain disorders, will be the director of the new research department which will have its headquarters here. Dr. Yerbury said that the new director will report at CSH July 20.

While some research has been carried on in the state hospital, it has depended upon individual initiative and has been hampered by lack of time and resources of those desiring to carry on such work. With the organization of the new department, it is hoped that the integration of effort may be made more effective.

In his research into neuro-pathology and neurobiology, Dr. Yakovlev will have access to the resources of the Yale Medical School and has been named to the Yale faculty as clinical associate professor of psychiatry. The faculty and students at Yale will have access to the resources at CSH.

The program also will include the development of courses and postgraduate seminars in psychiatry and related fields. The courses will begin with postgraduate seminars for physicians and later Dr. Yakovlev will conduct seminars for the students of the Yale Medical School.

The new research laboratory will be set up in close relationship to the present pathological laboratory at the hospital. Dr. Yakovlev will bring a collection and library of slides and specimens which he has been accumulating for the last quarter century.

Dr. Yakovlev comes to CSH from the Walter E. Fernald School at Waverly where he has been clinical director and director of research for several years. He previously served on the staff of the Monson State Hospital, Palmer, Massachusetts, and the Metropolitan State Hospital, Waltham, Massachusetts.

Born in Russia, Dr. Yakovlev received his bachelor of medicine degree at the University of Leningrad in 1920 and studied at the University of Paris for five years, receiving his doctor's degree there. During his studies in Paris he served as a foreign assistant in neurology to the late Professor Pierre Marie at Salpetriere Hospital, the institution in which the famous Charcot worked and where Freud was one of his students. He also studied under Dr. F. J. Babinski at LaPitie Hospital.

Dr. Yakovlev came to this country after graduation from the University of Paris and joined the staff of the Monson State Hospital. During his eight years at this hospital his research into epilepsy contributed much to the knowledge of the disease.

## Middlesex State Hospital's Summer Program

A medical intern and special dental program for the summer months has been instituted at Connecticut State Hospital to give senior and graduate students an opportunity for practical work in psychiatry and other fields, Dr. Edgar C. Yerbury, superintendent, announced recently.

Dr. Herbert R. Sleeper of Hartford is serving as

assistant dentist for three months, the superintendent reported. A graduate of Hartford schools, the University of Alabama and the University of Pennsylvania Dental School, Dr. Sleeper served in the Navy for the last two years and intends later to take postgraduate training in dental surgery.

Stanley N. Teale of Granby and Burton H. Lasker of New York City are serving as medical interns for three months. Mr. Teale is a senior medical student at Dalhousie University, Halifax, Nova Scotia, while Mr. Lasker is a senior medical student at the University of Illinois.

Dr. Yerbury also announced the appointment of Dr. Aldo Santiccioli of New York City as an assistant physician on the hospital staff. Dr. Santiccioli is a graduate of Columbia and the Medical School of the University of Bologna, Italy. He completed a year's residency in radiology at Bellevue Hospital, New York, and was in private practice in New York City for a year before coming to CSH.

### Grace-New Haven Hospital Starts New Building

The trustees of the Grace-New Haven Community Hospital Building Fund have announced that plans are being drawn to proceed at once with construction of a section of the basement of the proposed new building.

The sale of the William Wirt Winchester Hospital to the Veterans Administration has necessitated that new laundry facilities for the present hospital be provided, and these will be housed in the new basement, it is explained. Construction of the main part of the building must await the development of better conditions for building, according to Thomas I. S. Boak, chairman of the executive committee. At the present time the total funds raised by subscription amount to slightly over four million dollars. The committee plans to renew its subscription campaign this fall.

### New Britain Hospital Awarded Research Grant

The Research Grants Division of the National Institute of Health, USPHS, has awarded a research grant of \$24,516 for the fiscal year beginning July 1, 1947 to the New Britain General Hospital. The

investigation is under the direction of Dr. Paul D. Rosahn, pathologist at the hospital, and is concerned with a study of the biology of syphilitic infection in mice and rabbits. The project was begun in 1945 under the auspices of the Office of Scientific Research and Development. On January 1, 1946 administrative control was transferred to the United States Public Health Service which has supported the investigation since then.

### Wound Healing and the Plasma Ascorbic Acid Level

H. M. Carney reported in the *Annals of Surgery* in 1946 the results of a study of soldiers wounded during the Italian campaign of November, 1943, to ascertain whether ascorbic acid is a significant factor in causing failure of wound healing in clinical practice. Carney was able to determine the exact diets of the individuals for thirty days prior to the time they were wounded. Of 100 soldiers examined, 68 had wounds, an average of 2.6 wounds per patient. The average soldier in the group had had "C-rations" for nine days, "K-rations" for nine days, and other rations of known composition for specified periods of time.

No case of clinical scurvy was encountered and there was no unusual hemorrhage in the skin of any of the men. The admission plasma ascorbic acid levels of the 100 patients varied between 0.1 mg. and 2.35 mg. per cent. Of the 43 less seriously wounded or patients having operative incisions, only two failed to heal. The levels in these two were 0.2 mg. and 0.43 mg. per cent, respectively. Of the twenty-five seriously wounded patients, six failed to heal promptly. The level of ascorbic acid for the group of wound failures was 0.3 mg. per cent. In the remainder of the seriously wounded soldiers those who healed promptly, the level was 0.45 mg. per cent. It is of interest that in nine selected patients with repeated wound failures, the plasma ascorbic acid levels ranged from 0.5 to 1.44 mg. per cent.

This author could establish no relationship between plasma ascorbic acid and wound healing. Most of the cases of failure to heal were due to infection. It is his conclusion that, despite the experimentally established relationships, ascorbic acid deficiency may not be the principal basis for explanation of delayed wound healing.



# THESE THREADS MUST NOT BE BROKEN

A web of fine threads radiates from a medical organization to its members in every community.



Whenever one of these threads is weakened by apathy or indifference, the cause of free medicine loses ground.



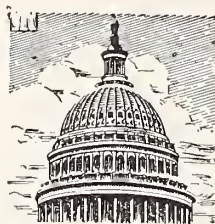
Physicians have many opportunities to mention their organizations in everyday talk — to remind people that these organizations represent the efforts of their doctors to realize better health and medical care for everyone.

Public Support is the  
Goal of Public Relations

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

Fairfield County, Charles H. Sprague, Bridgeport  
 Hartford County, Benjamin B. Robbins, Bristol  
 Litchfield County, W. Bradford Walker, Cornwall  
 Middlesex County, Richard H. Grant, Cromwell  
 New London County, Edmund L. Douglass, *Chairman*  
 Groton

New Haven County, Charles T. Flynn, New Haven  
 Tolland County, Leonard W. Levine, Ellington  
 Windham County, Brae Rafferty, Willimantic



# PUBLIC AFFAIRS

## SUBSTITUTE FOR HOUSE BILL NO. 33 — PUBLIC ACT NO. 254

### An Act Concerning the Detention of Mentally Ill Persons

*Be it enacted by the Senate and House of Representatives in General Assembly convened:*

Section 676c of the 1935 supplement to the general statutes is repealed and the following is substituted in lieu thereof: Any person who has suddenly become in need of care and treatment in a hospital for mental illness may be confined in such a hospital, either public or private, for not more than thirty days without order of any court, *provided, when proceedings in a probate court for commitment have been instituted but not completed at the end of such thirty days, such confinement may be continued without order until the completion of the probate court proceedings, and provided the superintendent of such hospital shall immediately discharge any patient found not to be mentally ill, or any person recovered from mental illness.* At the time of delivery of such person to such hospital, there shall be left, in the hands of the person in charge thereof, a certificate, signed by a physician licensed to practice medicine or surgery in Connecticut and dated not more than three days prior to its delivery into the hands of the person in charge of the hospital. Such certificate shall state the date of personal examination of the person to be confined, which shall be not more than three days prior to the date of signature of the certificate, shall state the findings of the physician relative to the physical and mental condition of the person and the history of the case, if known, and shall state that it is the opinion of the physician that the person examined by him is in need of immediate care in a hospital for mental illness. Prior to hospitalization under the provisions of this section any person shall have the right to be examined by a physician of his own choosing, and if such physician concludes from his examination that such person is not men-

tally ill, such person shall not be admitted to or detained in a hospital for mental illness under the provisions of this section. If such person shall have been admitted to any state hospital for mental illness, the person in charge thereof shall, immediately upon the delivery of such person to such hospital, notify the commissioner of welfare, in writing. *The commissioner of welfare shall, upon recommendation of the person in charge of such state hospital, cause proceedings to be instituted for the commitment of such person in the court of probate having jurisdiction in the town where such hospital is located, and, in case such person shall be committed upon application of the commissioner of welfare, he shall collect from the town in which such person has a settlement, or from such person or persons as may be liable for his support, the amount expended for such commitment and for the support and benefit of such person in the manner provided in sections 569e, 1745, as amended, and 250f, as amended. Except for voluntary admissions, if any person shall have been admitted to a private hospital for mental illness, the person in charge thereof shall, immediately upon delivery of such person to such hospital, notify the secretary of the public welfare council, in writing. Said secretary shall also be notified of the discharge of such patient before or at the termination of thirty days or of the pending or completed commitment of such person to such hospital by a court of probate. Except as provided above or when otherwise provided by statute, no person shall be committed or admitted to or detained in a hospital for mental illness without an order of a court of probate, provided any person in need of care and treatment in a mental hospital may be received and detained therein for not more than thirty days as provided in this section.*



## NEWS FROM WASHINGTON

### A REPORT ON PUBLICITY AND PROPAGANDA OF FEDERAL OFFICIALS IN THE FORMATION AND OPERATION OF HEALTH WORKSHOPS

**I**N MAKING public a report of the Subcommittee of the Committee on Expenditures in the Executive Departments authorized to investigate publicity and propaganda of Federal officials in formation and operation of health workshops, Representative Clare E. Hoffman, of Michigan, has made available to the public a document which is important for American medicine. To physicians who are not aware of some of the goings-on in certain government agencies its reading should be a revealing experience. Because it seems too important to be subjected to abstracting, the entire report appears herewith.

The committee, after full consideration of the report as submitted by the subcommittee, upon motion duly made and seconded, unanimously approved and adopted the report as the full Committee on Expenditures in the Executive Departments. The chairman was directed to transmit a copy of the report to the Speaker of the House of Representatives.

Your committee reports to the House that, on the basis of hearings held on May 28 and June 18, 1947, it finds that at least six agencies in the executive branch are using government funds in an improper manner for propaganda activities supporting compulsory national health insurance, or what certain witnesses and authors of propaganda refer to as socialized medicine, in the United States.

This report summarizes our hearings on this phase of the inquiry to date and presents the conclusions arrived at, following careful evaluation of the testimony and documentary evidence presented by, and relating to, the several Federal agencies involved.

The departments, bureaus, and agencies known to have participated in this campaign are:

1. The United States Public Health Service.
2. The Children's Bureau.
3. The Office of Education.
4. The United States Employment Service.
5. The Department of Agriculture; and
6. Bureau of Research and Statistics, Social Security Board.

Your committee finds that the use of Federal funds for the purpose of influencing legislation

before Congress is unlawful under section 201, title 18, of the United States Code. We have, therefore, brought these matters to the attention of the Department of Justice, with a request that the Attorney General at once initiate proceedings to stop this unauthorized and illegal expenditure of public moneys. A copy of the chairman's letter to the Attorney General is made a part of this interim report (exhibit 1).

Our exhibit 2, in this report, is a chart prepared by the committee staff, showing the number of Federal agencies and the number of Federal pay-roll personnel participating in the so-called health workshops arranged throughout the country during the last two years, to mobilize pressure groups in behalf of a national program for what certain witnesses and authors of propaganda refer to as socialized medicine.

The first meeting in furtherance of these health workshops was held in Washington, D. C., on November 2, 1945. At that meeting only 10 persons were present, all of them full-time employees of the Federal Government. George Perrott, of the United States Public Health Service, presided as chairman of the meeting. The Federal agencies represented in this meeting—and the representatives of these agencies were the only persons present—were United States Public Health Service, Department of Agriculture, and the Federal Security Agency.

The latest figures available from the Budget Bureau show that for the fiscal year 1946 total expenditures in the executive branch for publicity and propaganda activities were \$75,000,000. During that fiscal year 45,000 Federal employees were engaged, full or part time, in such activities. The most recent prior compilation by the Budget Bureau covering the fiscal year 1941 showed total publicity expenditures amounting to \$27,770,000. An increase of approximately 300 per cent in Federal expenditures for publicity and propaganda in a period of five years is deemed by your committee to be a proper subject for inquiry by the Congress.

It will be the purpose of your committee, in future interim reports, to examine this expenditure in detail by departments and agencies, with particular refer-

ence to illuminating those activities which are directed primarily to influencing the decisions of Congress on pending legislation.

Our first report deals exclusively with activities calculated to build up an artificial, federally stimulated public demand upon Congress for enactment of legislation for compulsory health insurance referred to by witnesses and publications as the Wagner-Murray-Dingell bill.

The extraordinary executive pressure exerted upon the staff of the United States Public Health Service to further the campaign for what certain witnesses and authors of propaganda refer to as socialized medicine is indicated by a letter sent under date of December 10, 1945, by Thomas Parran, Surgeon General of the United States Public Health Service, to all field men and staff operatives throughout the country. This letter referred to the message sent to Congress on November 19, 1945, by President Truman, urging enactment of a national health program. The Surgeon General's letter referred to the President's message as, "a subject of the highest importance to every citizen." His letter continues (hearing, May 28, 1947, p. 88):

"The appropriate executive agencies of the Government have been specifically instructed by the President to assist in carrying out this legislative program as presented to Congress on September 6, 1945."

The Surgeon General then listed the several health bills pending before Congress, continuing:

"Every officer of the Public Health Service will wish to familiarize himself with the President's message and will be guided by its provisions when making any public statement likely to be interpreted as representing the official views of the Public Health Service."

Pursuant to this policy, the Public Health Service launched its national program of health workshops.

Following the Washington conference of November 2, 1945, a broader planning conference was arranged at the University of Chicago, November 26-27, 1945. At this meeting 20 persons were present, 9 of whom were full-time employees of the Federal Government. The 11 non-Government persons in this meeting were representatives of the CIO, A. F. of L., and the Farmers Union.

Next the planning committee met in Washington, D. C., on December 10, 1945, to evaluate the Chicago meeting and plan for the health workshops. The first health workshop was held in St. Paul, Minn.,

February 6-10, 1946, with 80 persons participating, 15 of whom were Government employees, representing 7 different agencies in the Federal establishment.

The second health workshop was held in Jamestown, North Dakota, September 27-30, 1946, with 98 persons participating, 18 of whom were Federal employees, representing 7 Federal agencies. The chairman of this meeting was Dr. Mayhew Derryberry, PH.D., of the United States Public Health Service. Apart from Federal personnel, there were no doctors of medicine in attendance at this meeting as delegates. The testimony before your committee indicates that no registered doctor of medicine was invited to participate.

All the evidence before your committee indicates that these health workshops were planned, conducted, and largely financed with Federal funds, by a key group on the Government pay roll, who used the workshop method of discussion subtly to generate public sentiment in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine. It is evident from the record that most of the planning was done by the Federal officials in Washington prior to each workshop conference and that each meeting was devoted to their own purposes—that of organizing pressure groups to agitate for compulsory health insurance, as then pending in Congress.

In preparation for the Jamestown Health Workshop, the Public Health Service distributed in advance to all delegates a packet of pamphlets published by the CIO, A. F. of L., the Physicians' Forum (a propaganda agency for the Wagner-Murray-Dingell bill), and the Government bureaus, in support of what certain witnesses and authors of propaganda refer to as socialized medicine. These packets were mailed to the delegates in advance of the conference, at Federal expense. They urged that letters be written to Senators and Representatives, advocating immediate action on the Wagner-Murray-Dingell bill.

After the propaganda packets had been delivered, well in advance to the invited delegates, the Jamestown Health Workshop assembled on September 27.

Your committee received a detailed account of this health workshop from Mr. E. F. Engebretson, executive secretary of the North Dakota State Medical Association, who attended as an uninvited observer. On June 18, 1947, Mr. Engebretson testified:

. . . The meeting began on Friday, September



27. Friday was spent in its entirety in a so-called training program. The sponsoring organizations had invited various Federal and State officials to attend the conference as so-called consultants. Twenty-one of these consultants were in attendance, of which 19 were Federal employees and 2 were employees of the State of North Dakota.

The training session the first day was not open to the general membership of the Farmers' Union or other groups sponsoring the program. Rather, a hand-picked group of leaders from the various local societies were brought in for the purpose of being trained in workshop procedure. This training program was handled entirely by the employees of the Federal Government. In charge of the program, in a general way, was Dr. Mayhew Derryberry, Chief of the Office of Health Education, United States Public Health Service. In charge of the training instructions was a Dr. Hubert Stanley Coffey, Chief of Training, Federal Security Agency. The hand-picked group from the local societies were designated as delegates, and in training them, they were seated around a conference table with the 21 consultants lined up behind them. . . .

After the training program, the indoctrinated delegates were given 30-minute tests to measure their leadership ability by setting forth the immediate health needs of North Dakota. At this point, Witness Engebretson testified:

. . . It was very interesting to note that when left to themselves the delegates seemed unable to think of any particular health problems in the State. . . .

Your committee then obtained from the Federal Security Agency a full copy of the instruction sheets used by the training officers at these health workshops. Among the topics listed are:

Techniques for the organization of citizen groups.

Formation of pressure groups.

Methods of bringing about group action.

Testimony demonstrating the efficacy of this indoctrination of delegates by the Federal officials was found in the formal summary of the Jamestown Workshop, as presented by the United States Public Health Service.

One section of the "action program," approved by the conference, urged "that congressional candidates and incumbents be polled by the committee, on their stand on the national health program, and that their opinions be sent to the State organizations

for publication."

In the opinion of your committee, this recital presents the complete picture of Government propaganda in action. The Federal employees arrange the meeting, invite the delegates, train the delegates, preside at the meetings, and then frame the formal summary of resolutions and actions.

And all of this is paid for with public moneys never authorized or approved by Congress for these or any like purposes.

Testimony before the committee indicates also that the staff and resources of the Bureau of Research Statistics in the Social Security Board were devoted freely, from time to time, to the preparation of pamphlets and propaganda literature for the CIO, the AFL, and the Physicians' Forum. Much of this material prepared for the CIO and other groups, by the Social Security Board at Government expense, supported what certain witnesses and authors of propaganda refer to as socialized medicine in every approach and dismissed contemptuously all arguments controverting the fixed position of the Social Security Board (hearing, p. 170).

Your committee concludes from the testimony that most, if not all, of this literature, as distributed by the CIO, the AFL, the Farmers' Union, and the Physicians' Forum originates in, and emanates from, the Bureau of Research and Statistics in the Social Security Board. Mr. Isadore Falk is Director of the Division of Research and Statistics in the Social Security Board. His principal assistant, Miss Margaret Klem, was a witness before your committee on June 18. Miss Klem was identified as Chief of the Medical Economics Section of Mr. Falk's Division. She was one of the group of Federal employees who charted, arranged, and conducted the Jamestown Health Workshop. The testimony discloses also that she helped draft the Wagner-Murray-Dingell bill.

At a later date, your committee will submit a separate detailed report on the activities of the Social Security Board during the last 10 years in behalf of what certain witnesses and authors of propaganda refer to as socialized medicine.

Other evidence before the committee reveals that the Bureau of Research Statistics of the Social Security Board also prepared pamphlets and propaganda material to be distributed under the imprint of the CIO. Similar pamphlets were prepared in the same office for distribution as Government literature through the Department of Agriculture's Inter-

bureau Committee on Postwar Programs. All this material, as presented in our hearings, is similar in tone, content, and objective. It all originates in one spot, in the Social Security Board. It is all paid for, save the actual printing, by a process which your committee deems an improper use of Federal appropriations.

Samples of all these pamphlets and propaganda leaflets are available in your committee's files for examination by the public. Photostatic copies of some of them have been transmitted to the Attorney General, with our request for action in defense of the American taxpayers, who are paying the bill.

The spirit and purpose which dominates the officials of the United States Public Health Service in their campaign to high-pressure this legislation through Congress is reflected faithfully in the testimony of Dr. Herman Hilleboe, Assistant Surgeon General, who appeared before the committee on May 28, 1947. He was asked by our committee chairman if the literature prepared by the Federal agencies offered all sides of the discussion or was limited merely to supporting material to carry out the President's order. To this question, Dr. Hilleboe answered:

"We would naturally give emphasis to that, because that is why we are in Government. Otherwise, we should get out of Government."

The same attitude of intolerance toward honest discussion or debate of the issue was indicated in the testimony of Mr. Harry J. Becker, health consultant in the United States Children's Bureau, Federal Security Agency.

Questioned as to the number of speeches he had made throughout the country in advocacy of the subject, the witness recalled several such appearances. Committee counsel, Frank T. Bow, pressed the inquiry (hearing, June 18, 1947, p. 228):

Mr. Bow. Did you give both sides of the question of compulsory national health insurance when you gave your discussions?

Mr. Becker. I don't know what you mean by "both sides."

The Children's Bureau, Federal Security Agency, was represented in the health workshops movement by Mr. Harry J. Becker, a full-time employee of the Federal Security Agency, in the capacity of health consultant. Mr. Becker, while engaged in his Federal position, also was one of the principal organizers of the Group Health Association of Washington, D.

C., of which he later became president. He is also vice-president of Cooperative Health Federation of America, which he helped organize in meetings at Two Harbors, Minn., and Columbus, Ohio, while on the full-time pay roll of the Children's Bureau.

In this connection, your committee recalls that it was the activities of the Group Health Association of Washington, D. C., which led to the filing, in 1937, of the antitrust proceeding against the Medical Society of the District of Columbia and the American Medical Association under the Sherman Antitrust Act.

This legal action by the Department of Justice was carried to the Supreme Court of the United States on the basis of the original complaint and accusations of Group Health Association of Washington, D. C., serving effectively to intimidate and restrain the activities of the American Medical Association in resisting the Federal propaganda.

Mr. Becker was a witness before your committee on June 18. His testimony delineates in some detail the historical development of the movement within the Federal Government to set up, at Federal expense, a Nation-wide campaign in support of pending legislation. Your committee invites particular attention to the testimony and cross-examination of Mr. Becker, because we feel that the devices and arrangements of Federal employment in this instance provide a typical example of how funds appropriated by Congress for the legitimate expenses of Federal agencies are diverted within the bureaus to full-time propaganda for what certain witnesses and authors of propaganda refer to as socialized medicine.

Not only are men and women paid substantial salaries in their Federal positions for their full-time activities in other fields, but in many instances traveling expenses and incidental costs of these pressure-group meetings are paid out of funds of the same Federal agencies.

Your committee has, for example, a report from the General Accounting Office, showing that various Federal agencies paid out a total of \$1,950 in traveling expenses of Federal employees to and from the Jamestown Health Workshop. This conference took 18 Federal officials away from their desks for a total of 126 man-days.

Another report from the General Accounting Office shows that the Federal Government paid almost \$5,000 in traveling expenses of Federal em-



employees for the series of five health workshop conferences and planning meetings held throughout the country before our investigation began.

Certain documentary evidence also has come to the attention of your committee, that the Bureau of Research and Statistics in the Social Security Board also maintains close contact with movements for compulsory health insurance in other countries.

Under date of May 14, 1947, Mr. Isadore Falk, director of the Bureau of Research and Statistics, sent a memorandum to the Acting Commissioner for Social Security, urging that one Jacob Fisher, a member of Mr. Falk's staff, be sent to New Zealand at Government expense, to study compulsory health insurance programs and activities in that nation.

We find that this same Jacob Fisher has been documented by the House Committee on Un-American Activities for almost uninterrupted association, since 1939, with various Communist-front and fellow-traveler organizations in the United States. At various times, according to this record, Jacob Fisher has been identified with seven different groups or organizations avowedly sponsoring the Moscow party line in the United States. He has published at least one report on health insurance in New Zealand, in the *Social Security Bulletin*—a report which has been criticized by some reputable medical authorities as extremely biased.

In a later interim report on the propaganda activities within the Social Security Board, we shall present to the Congress the detailed record of Jacob Fisher's activities, as certified to us by the Committee on Un-American Activities, together with additional material bearing upon organized Communist agitation for what certain witnesses and authors of propaganda refer to as socialized medicine, through such agencies as the Southern Conference for Human Welfare.

Suffice it at this time for your committee to report its firm conclusion, on the basis of the evidence at hand, that American communism holds this program as a cardinal point in its objectives; and that, in some instances, known Communists and fellow-travelers within the Federal agencies are at work diligently with Federal funds in furtherance of the Moscow party line in this regard..

Approved:            Forest A. Harness, *Chairman*  
                  James W. Wadsworth     Carter Manasco  
                  Henry J. Lathan             J. Frank Wilson

## Conclusions of Representative of United Public Health League

Having heard approximately 400 witnesses testify, having sat through several months of hearings during the 78th, 79th and 80th Sessions of Congress, I have come to the conclusion that there is still a wide breach between proponents of Socialized Medicine and those favoring more evolutionary changes in the costs of medical care and its distribution. A great deal of loose thinking is apparent on the part of both sides when one reads the testimony presented. Monopoly of the American Medical Association, as charged by proponents of Socialized Medicine, as well as the use of such terms as Communism and Fascism, have helped to widen this breach. S1320 is a socialized trend that cannot be refuted and should be faced squarely and debated in the open. It is not as yet Communistic.

Medicine and the opponents of Socialized Medicine have left many charges and false statements unchallenged. There has been no attempt to co-ordinate or correlate many very able arguments presented by those favoring the evolutionary changes, while a very clever organization, the Committee for the Nation's Health, has succeeded in presenting its witnesses in a manner which is striking in its ability to continue pounding away daily on a fixed pattern. Daily press releases in advance of the appearance of their witnesses were generally available. All this was conspicuously absent in the case of Medicine and its friends.

The Senate Committee holding hearings on this legislation has demonstrated only a latent interest. Senator Donnell, as usual, carries the ball, but Dr. Shearon's position as persona non grata with the Committee members on the left has weakened the Senator's position.

Too much time has been spent in personalities involving her activities and usually Senators Smith and Taft have given in to Murray, Pepper and Aiken. Taft is too busy to take much interest in the subject. He was present only on the opening day.

I would say in conclusion it is evident that Medicine has been fighting a rear guard action and has not shown enough active fighting spirit or has failed to recognize the urgency of its case and only a small segment of the public or business has shown any concern, while labor and the group fighting for their case are militantly organized.

## THE DOCTOR'S OFFICE

Clement C. Clarke, M.D., announces the removal of his offices to 240 Bradley Street, New Haven.

Herman Edelberg, M.D., and Eileen Edelberg, M.D., announce the opening of offices for the practice of medicine on Hopmeadow Street, Simsbury.

Benjamin Katzin, M.D., announces the opening of an office for the practice of internal medicine and cardiology at 106 Litchfield Street, Torrington.

Thomas M. Monagan, M.D., announces the opening of an office for the practice of medicine at 195 Grove Street, Waterbury.

Victor J. Mulaire, M.D., announces the opening of an office for the practice of urology at 65 South Street, Stamford.

Thomas P. Mullaney, M.D., announces the opening of an office for the practice of medicine at 29 North Main Street, Windsor Locks.

John J. Murphy, M.D., announces the opening of an office for the practice of medicine at 27 Wells Avenue, East Hartford.

Sidney L. Penner, M.D., announces the resumption of the practice of internal medicine at 2692 Main Street, Stratford.

A. F. Resnisky, M.D., formerly at 57 Pratt Street, Hartford, has reopened his office at 11 Asylum Street.

Rolando R. Ruiz, M.D., announces the opening of an office for the general practice of medicine and obstetrics at 246 Main Street, Danbury.

Frank A. Serena, M.D., announces that he has resumed association with the Padula Clinic in the practice of orthopedic surgery at Norwalk.

H. P. Stetson, M.D., announces the opening of an office for the practice of medicine at 162 Main Street, Southington.

Lloyd P. Williams, M.D., announces the opening of an office for the practice of pediatrics at 404 Farmington Avenue, Hartford.

A. J. Zujko, M.D., announces the opening of an

office for the practice of women's diseases at the Hotel Putnam, Putnam.

### Dr. Howard's Testimony Lost

On July 23 Senator Smith of New Jersey abruptly ended the Senate Committee on Education and Labor hearings in order to remove any possible obstacle from the adjournment of Congress. By this sudden action the testimony of Joseph H. Howard of Connecticut was lost for the present but may be heard when the committee resumes its activities next January. Dr. Howard was waiting to testify on behalf of the A.M.A. to refute some of the charges made against organized medicine by witnesses against S545 and for S1320.

### Dr. Martha Eliot Consultant for U. N. Survey

Dr. Martha M. Eliot, associate chief, United States Childrens' Bureau, and president-elect of the American Public Health Association, will be chief medical consultant for a United Nations survey of the relief programs being carried out in Central and Eastern Europe.

A member of the Connecticut State Medical Society, Dr. Eliot is now on leave from the Childrens' Bureau to assume her new duties. The medical section of the survey will include the inspection of children's institutes and other facilities in seven European countries. The survey will be conducted by the International Childrens' Emergency Fund of the United Nations Organization, under the direction of Dr. Ludwig Rajchman, chairman of the board which operates the fund.

Dr. Eliot received her medical degree at Johns Hopkins University School of Medicine in 1918, and graduated from Radcliffe College in 1913. She was licensed to practice medicine in Connecticut in 1921. A diplomate of the American Board of Pediatrics, she is also a member of the American Pediatrics Society and the American Academy of Pediatrics.



# MEDICINE AND THE VETERAN

## COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*

EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven

JOSEPH N. D'ESOP, New Haven

### New Appointments at Newington Hospital

Appointments of fourteen new resident physicians to the medical staff of the Veterans Administration Hospital in Newington have been announced by Dr. Lewis G. Beardsley, manager.

The appointments bring to 28 the total number of resident physicians at the hospital who are preparing for specialty board ratings.

The newly appointed residents and their specialties are: John J. Beck, Wantoma, Wis., surgery; John M. Duffy, Jr., Wellesley, Mass., anesthesiology; Edward G. Howe, Passaic, N. J., internal medicine; John J. Korab, Middletown, internal medicine; Harold J. Lehmus, West Hartford, internal medicine; Robert I. Lowenberg, Summit, N. J., surgery; Jean E. Neighbor, Kirkland, Washington, internal medicine; Nicholas P. R. Spinelli, Stratford, internal medicine; Theodore R. Struhl, Brooklyn, N. Y., surgery; Anthony Zovickian, Watertown, Mass., surgery; Alfred J. Kummer, Yonkers, N. Y., radiology; Clyde Sussman, Hartford City, Indiana, otolaryngology; Herman S. Shapiro, Brooklyn, N. Y., surgery; and Francis A. Spellman, Concord, N. H., internal medicine.

### Dr. Welt Goes to VA in Washington

Dr. Louis G. Welt, clinical instructor of medicine at Yale University School of Medicine, and practitioner of internal medicine in Willimantic, has received appointment to a medical research post with the Veterans Administration in Washington, D. C.

Dr. Welt received his medical degree at Yale University School of Medicine in 1938. He is a graduate of New York University, and has practiced medicine in Connecticut since 1939. During World War II he was Pacific editor for the *Journal of Military Medicine*, and specialized in the control of malaria. A member of the American Medical Association and local and state medical organizations, he is also a member of the American Society of Tropical Medicine.

### Termination of War

July 25, 1947 is a day to remember. Following a joint resolution by Congress, the President established July 25, 1947 as the official end of World War II for the purpose of defining periods of eligibility for certain Federal benefits.

The following are the most important effects of this proclamation:

#### READJUSTMENT ALLOWANCE

To be eligible for the Readjustment Allowance under the provisions of the Servicemen's Readjustment Act of 1944, the veteran "must have served in the active military or naval service of the United States (or its Allies, according to Public Law 268) at any time after September 16, 1940 and prior to the termination of the war." The act further provides that payment will be made for unemployment which "occurs not later than two years after discharge or release or the termination of the war, whichever is the later date" and that "no Readjustment Allowance shall be payable for any week commencing more than five years after the termination of hostilities in the present war."

This means that since the war terminated on July 25, 1947 eligible veterans discharged on or before that date have until July 25, 1949 to receive the Readjustment Allowance. Eligible personnel still in service will have until two years of their discharge to apply for the Readjustment Allowance but no payment will be made for any week of unemployment beginning after July 25, 1952.

#### EDUCATION

Education and training benefits under the G.I. Bill provide, "that such course shall be initiated not later than four years after either the date of discharge or the termination of the present war, whichever is later: provided further that no such education or training shall be afforded beyond nine years after the termination of the present war." Public Law 16, as amended, imposes the same time limitation for the *completion* of vocational rehabilitation.

This means that education or training under the G.I. Bill or vocational rehabilitation under Public Law 16, as amended, must be completed on July 25, 1956. Under Public Law 346, education or training must be begun by July 25, 1951, but may be begun at any time under Public Law 16.

#### LOANS

The Servicemen's Readjustment Act states that: "any loan made by such veteran within ten years after the termination of the war . . . is automatically guaranteed by the Government . . ."

The termination of the war means that the 10-year period within which veterans must apply for a loan guarantee under Public Law 346 will expire on July 25, 1957.

### Terminal Leave Bonds Cashable

The President has signed into law, after its passage without a dissenting vote by Congress, an act which permits veterans to *redeem*, after September 1, 1947 their Terminal Leave Bonds at full value plus interest. The law does not require that the bonds be cashed and veterans may keep them until they have matured, five years from their date of issue, drawing full interest at the rate of 2½ per cent a year.

The Treasury Department is drafting plans whereby the bonds may be cashed at any bank in the same manner as are Government Savings Bonds.

The forms "Claim for Settlement—Unused Leave" may be obtained at any post office, and official application forms for the replacement of Terminal Leave Bonds that may have been lost or destroyed may be obtained by writing to the Chief, Division of Loans and Currency, U. S. Treasury Department, Washington 25, D. C. The request for this form should be accompanied by a full explanation of the circumstances surrounding the loss and as thorough a description of the bond as possible.

Under the new law, veterans who have not as yet filed for their Terminal Leave Bonds will have until September 1, 1948, to do so and will have the option of taking cash or bonds.

A joint Treasury-War-Navy Department estimate shows that some 1,916,000 veterans have yet to file for the bonds. This total is broken down as follows by the Services: Army, 1,250,000; Navy, 500,000; Marine Corps, 113,000; Coast Guard 53,000.

Veterans should be advised not to overlook the

fact that the Terminal Leave Bonds will continue to draw 2½ per cent interest a year and may be cashed at some future date when the veteran, or his beneficiary, may be in more urgent need of the money than now. It should also be pointed out that the Bonds may be deposited with the Veterans Administration as payment or prepayment on National Service Life Insurance.

### Veterans in Medical Schools

One of every thirty veterans in school under the G.I. Bill is studying medicine or related subjects, a Veterans Administration sampling of school-going veterans disclosed.

Of the total of 1,825,000 veterans in schools, colleges and universities on May 1, the survey showed 59,316 enrolled in all phases of medical training.

Nearly 53,000 of these veteran-students were in colleges and universities, and the remaining 6,500 were in other types of educational institutions studying nursing, x-ray procedures and related subjects.

Most of the veterans in school on May 1—or 1,126,000—were in colleges and universities. The remaining 699,000 were in high schools, trade schools and other institutions at the non college level.

Under the Servicemen's Readjustment Act (G.I. Bill), veterans are eligible for education at Government expense if they served in the armed forces for 90 days or more, part of which was on or after September 16, 1940, and they were released under conditions other than dishonorable.

The period of education to which a veteran is entitled depends upon the length of active military duty. He receives one year, plus one month for each month of military service, up to a maximum of four years.

While in school, he may receive a subsistence allowance from VA of \$90 a month if he has dependents or \$65 a month if he has none—provided he has no other income.

### Eligibility for Bronze Star Medal

The War Department has recently ruled that all veterans who were cited individually for their part in ground combat during the period December 7, 1941 to September 2, 1945 will be eligible for award of the Bronze Star Medal.



According to a memorandum of the State Veterans Advisory Commission, orders granting the Combat Infantryman's or Combat Medical Badges may be used to support claims for the Bronze Star Medal. General orders or formal certificates issued to individuals for their acts may also be used. Applications for the award must be submitted to the Adjutant General, Washington 25, D. C. The application must cite paragraph 15.1 (c) A. R. 600-45, and a copy of the citation or order awarding the Combat Infantryman or Combat Medical Badge must be enclosed.

### To Secure State Bonus

Former officers of the United States Public Health Service who are eligible to apply for the Connecticut veterans' bonus should furnish the following documents with their applications, according to Joseph A. Adorno, state treasurer:

1. Documentary evidence indicating the applicant as being an officer of the United States Public Health Service prior to assignment to duty with any component of the armed forces.
2. Orders authenticating the applicant's call to duty, and his assignment to a branch of the armed forces between the dates of December 7, 1941 and December 3, 1945.
3. Documentary evidence showing honorable termination of military or naval service.
4. Completion of Form 1 if applicant still resides in the state, or completion of Form 2 if applicant is now living out of the state.

### Certificates in Lieu of Discharges

Connecticut naval veterans desiring to obtain certificates in lieu of lost discharges or notices of separation (NAVPERS 553) should apply for such certificates to: Commandant, Third Naval District, Federal Office Building, 90 Church Street, New York City, attention Civil Readjustment Officer.

A recent memorandum published by the State Veterans Advisory Commission points out that the records of all naval personnel who were residents of Connecticut at time of separation are on file at the above office.

### "Lapsed" National Service Life Insurance

"I'm getting notices that my NSLI has lapsed, but I have been paying my insurance premiums right along. What should I do?"

This question is frequently asked by veterans concerning their National Service Life Insurance. It is answered by Arthur M. Grayson, Veterans Insurance Officer for Connecticut, as follows:

"First, let me emphasize that as long as the veteran has paid and continues to pay his premiums, he needn't worry that his insurance has lapsed. His insurance is in force and he is protected.

"He may be receiving notices that his insurance has lapsed because his records are incomplete or have not as yet reached the branch office in Boston which administers the NSLI program for New England veterans. Or the veteran may be at fault himself. He may have failed to give the full information required when he sends in his insurance payments. When making an insurance premium payment, the veteran should indicate his full name, address, and insurance certificate number.

"If necessary, the veteran can help the VA get his records in shape by submitting proof of payments, such as photostatic copies of cancelled checks or receipts of all payments that have been made.

"Veterans who are receiving lapse notices despite the fact that they have been making the proper premium payments should call at their nearest VA office to set the wheels in motion to get their records straightened out and up to date."

### Dr. Anderson Assumes Duties as Head of Medical Education Council

Donald G. Anderson, M.D., former dean of the Boston University School of Medicine, has taken up his new duties as Secretary of the Council on Medical Education and Hospitals of the American Medical Association. He succeeds Victor Johnson, M.D., who recently was appointed director of the Mayo Foundation for Medical Education, at Rochester, Minnesota.

Dr. Anderson is a graduate of Harvard College and received his M.D. degree from Columbia. He has had hospital and academic appointments at Boston City Hospital, Presbyterian Hospital in New York, Evans Memorial and Massachusetts Memorial Hospitals in Boston, and Columbia. During the war he was associated with Dr. Chester Keefer in penicillin research for the Office of Scientific Research and Development. His research publications deal primarily with the employment of the sulfa drugs, penicillin and streptomycin in the chemotherapy of infections.

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## STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

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### THE POLIOMYELITIS SEASON APPROACHES

With the coming of the warm weather, you are once more faced by the problems associated with poliomyelitis. Although the character the disease will take on for the coming year is unknown, from past performances there is the indication that this may be a year of increased prevalence in some parts of the state.

Attached find a table giving the cases of poliomyelitis reported in Connecticut by months up until the present time. This will give you an idea of the past history of this disease in Connecticut and also indicate what we may possibly expect for the coming season. Also, attached is a statement on poliomyelitis facilities in Connecticut prepared by this department in order to give you as much information as possible to aid you in handling the patients you might see, and a bulletin on precautions to be observed during the poliomyelitis season.

Regulation 7 of the sanitary code indicates that any suspicious case of poliomyelitis and certain other diseases should be reported to the local health officer without waiting for a definite diagnosis. Your local health officer will be glad to assist you in making a diagnosis if you so desire. Also, at the request of your local health officer a physician from this office is available to aid you in the diagnosis of a suspicious case.

It is a well known fact that the hospitalization of a patient with acute poliomyelitis for treatment during this stage is an advantage to the patient. It is also recognized that traveling a long distance to a hospital may not be conducive to the best interests of the patient. General hospitals may accept poliomyelitis cases where facilities for satisfactory isolation can be set up. It is possible that your local hospital may accept poliomyelitis cases if the emergency arises. This you can check through your local health officer. (See also enclosed statement on poliomyelitis facilities prepared by this bureau and the division of crippled children.)

If a patient is to be removed to a hospital in another town or out of state, you should contact your

local health officer to check the manner in which this can be carried out.

Many of you are giving medical service to a children's institution or a summer camp during this season. In such case, you might like to advise the person in charge of such institution or camp in regard to precautionary measures should poliomyelitis appear in these areas, as well as for the isolation of any patient who develops suspicious symptoms. In this way, you may protect these areas.

At this season, there is always some discussion as to the possible relation of tonsillectomy to poliomyelitis, especially the bulbar type. The significance of the evidence on this point I will leave to your judgment. This matter appears worthy of careful consideration as to the possibility of criticism if by chance a case should occur soon after an operation.

### Poliomyelitis Facilities in Connecticut

#### DIAGNOSIS

A physician may request assistance in diagnosis from the local health officer. At the request of the health officer, a physician from the bureau of preventable diseases of the state department of health will visit the patient for diagnostic or epidemiological study.

#### HOSPITALIZATION FACILITIES

*Acute cases*—Most patients are hospitalized during the acute state of illness. The isolation hospitals in Connecticut are the John James McCook Memorial Hospital, Hartford; the New Haven Hospital; Englewood Hospital, Bridgeport; the Mitchell Ward of the Lawrence Memorial Hospital, New London; the Stamford Hospital and the Nathaniel Witherell Hospital.

Any general hospital may set up an isolation unit for patients with acute poliomyelitis. When general hospitals plan to set up facilities for care of patients with poliomyelitis, it is only natural they should make as many of the important services available as possible through their own resources. Many general hospitals have on their staff, physicians, orthopedists,



nurses and physical therapists who have had experience in treating patients with poliomyelitis.

When hospitals do not have trained personnel on their staff, the state department of health will give consultation, assist in securing personnel and furnish personnel during an emergency until trained personnel can be secured.

*Convalescent patients*—Patients are discharged from isolation hospitals to convalescent institutions or other convalescent facilities for treatment as soon as the quarantine period is over, depending upon the condition of the patient and upon availability of convalescent facilities. For example, if a patient is too ill to be moved, or if convalescent facilities are for the moment not available, he may be cared for in the general hospital associated with the isolation unit. The special facilities providing convalescent care for patients are as follows: the John James McCook Memorial Hospital, Hartford; Newington

Home for Crippled Children; the Children's Center, New Haven; and the Englewood Hospital, Bridgeport.

These convalescent institutions provide pediatric, medical, orthopedic, nursing and physical therapy services. Some of these institutions also provide the services of medical social workers and occupational therapists.

Convalescent care may also be provided in the patient's own home. Decision to plan for such care on discharge from the hospital would depend upon medical recommendations, social study and existing medical, nursing and social resources.

PHYSICAL THERAPY

Physical therapy services are available through hospital convalescent institutions, clinics, or state physical therapy centers in the following cities and towns:

TOWN	LOCATION OF PHYSICAL THERAPY FACILITIES
Bridgeport - - - -	Bridgeport Hospital; St. Vincent's Hospital; Englewood Hospital; The Physical Therapy Clinic of the Bridgeport Chapter of the Connecticut Society for Crippled Children and Adults, Bridgeport
Danbury - - - -	Danbury Hospital†
Derby - - - -	Griffin Hospital*
Griswold - - - -	St. Marys' School, Jewett City*
Hamden - - - -	Children's Center
Hartford - - - -	John James McCook Memorial Hospital; St. Francis Hospital; Hartford Hospital
Meriden - - - -	Meriden Hospital
Middletown - - - -	Middlesex Hospital
Monroe - - - -	Monroe School*
Naugatuck - - - -	Naugatuck Red Cross*
New Britain - - - -	New Britain General Hospital
New Haven - - - -	New Haven Hospital; Grace Hospital
Newington - - - -	Newington Home for Crippled Children
New London - - - -	New London School Clinic*
New Milford - - - -	New Milford Visiting Nurse Association*
Newtown - - - -	Visiting Nurse Association*
Norwalk - - - -	Norwalk Hospital
Norwich - - - -	William W. Backus Hospital†
Plainfield - - - -	Public Schools in Plainfield and Moosup*
Putnam - - - -	Day Kimball Hospital*
Stafford Springs - - - -	Visiting Nurse Association*
Stamford - - - -	Stamford Hospital;* St. Joseph's Hospital
Thomaston - - - -	Visiting Nurse Association*
Thompson - - - -	St. Joseph's School, North Grosvenordale*
Torrington - - - -	Charlotte Hungerford Hospital*
Vernon - - - -	Rockville Visiting Nurse Association*
Waterbury - - - -	St. Mary's Hospital; Waterbury Hospital*
Waterford - - - -	Waterford School*
Watertown - - - -	Visiting Nurse Association*
Winchester - - - -	Winsted Visiting Nurse Association*
Windham - - - -	Windham Community Memorial Hospital, Willimantic†

\*State Technician  
†State and Hospital Technicians

FOLLOW-UP SERVICES

After discharge from the hospital or convalescent home follow-up services (medical, orthopedic, physical therapy, public health nursing, etc.) may be provided through the patient's physician, or at orthopedic or special poliomyelitis clinic.

CLINIC SERVICES

Under the auspices of the Hartford County Chapter of the National Foundation for Infantile Paralysis, a monthly clinic is held at the Hartford Hospital. At this clinic patients are followed who were hospitalized at the Isolation and Convalescent units of the McCook Hospital or who were treated at home.

New Haven Hospital orthopedic clinic furnishes services for patients from New Haven County and part of Fairfield County.

The Physical Therapy Clinic of the Bridgeport Chapter of the Connecticut Society for Crippled Children and Adults gives services to children living in Bridgeport and surrounding towns.

Newington Home for Crippled Children receives patients referred from various parts of the state for care following the isolation period. It gives follow-up services through its clinics at the Home.

Clinics of the division of crippled children of the

state department of health care for patients on referral who have been discharged from hospitals or convalescent homes and are living in areas close to the clinics. These clinics are conducted monthly in the following hospitals:

- Danbury—Danbury Hospital.
- Derby—Griffin Hospital.
- Norwich—William W. Backus Hospital.
- Putnam—Day Kimball Hospital.
- Stamford—Stamford Hospital.
- Torrington—Charlotte Hungerford Hospital.
- Willimantic—Windham Community Memorial.

In some instances children are given medical care by a local hospital or clinic but the state department of health may still be requested to supply other related services such as nursing, physical therapy and medical social services.

A supply depot is maintained in Boston by The National Foundation for Infantile Paralysis from which respirators, machines for preparing hot packs and material for packs can be furnished within 24 hours in case of need. In order to obtain this equipment contact The National Foundation for Infantile Paralysis, 120 Broadway, New York City. When ordering a respirator from any source check whether the machine requires DC or AC current.

RESPIRATORS IN CONNECTICUT

TOWN	COUNTY	HOSPITAL								NO.
Bridgeport	Fairfield	Bridgeport Hospital	-	-	-	-	-	-	-	1
		Englewood Hospital	-	-	-	-	-	-	-	2
Danbury	Fairfield	Danbury Hospital	-	-	-	-	-	-	-	1
Hartford	Hartford	Connecticut State Department of Health	-	-	-	-	-	-	-	4
		Hartford Hospital	-	-	-	-	-	-	-	2
		John James McCook Memorial Hospital	-	-	-	-	-	-	-	2
Meriden	New Haven	Meriden Hospital	-	-	-	-	-	-	-	1
Middletown	Middlesex	Middlesex Hospital	-	-	-	-	-	-	-	2
New Britain	Hartford	New Britain Health Department	-	-	-	-	-	-	-	1
New Haven	New Haven	Hospital of St. Raphael	-	-	-	-	-	-	-	1
		New Haven Hospital	-	-	-	-	-	-	-	4
		Lawrence & Memorial Associated Hospitals	-	-	-	-	-	-	-	2
New London	New London	Norwalk General Hospital	-	-	-	-	-	-	-	1
Norwalk	Fairfield	William W. Backus Hospital	-	-	-	-	-	-	-	2
Norwich	New London	Sharon Hospital, Inc.	-	-	-	-	-	-	-	1
Sharon	Litchfield	Stamford Hospital	-	-	-	-	-	-	-	1
Stamford	Fairfield	Charlotte Hungerford Hospital	-	-	-	-	-	-	-	1
Torrington	Litchfield	St. Mary's Hospital	-	-	-	-	-	-	-	1
Waterbury	New Haven	Waterbury Hospital	-	-	-	-	-	-	-	1
Total			-	-	-	-	-	-	-	31



## FINANCIAL ASSISTANCE

Financial assistance for individual care of patients with poliomyelitis may be obtained by applying to the County Chapters of the National Foundation for Infantile Paralysis. The physician or family may communicate with the chairman of his County Chapter or with the state office of the Foundation at 36 Pearl Street, Hartford. The following is the list of the chairman of the various chapters:

- Fairfield County—Judge Paul V. Cavanaugh  
P. O. Box 206, Newtown
- Hartford County—David A. Wilson  
75 Pearl Street, Hartford
- Litchfield County—P. Francis Hicks  
34 Rock Street, Winsted
- Middlesex County—M. L. Palmieri, M.D.  
54 Broad Street, Middletown
- New Haven County—Prof. Ira V. Hiscock  
Yale University, School of Public Health,  
New Haven
- New London County—Charles W. Cassidy  
63 Broadway, Norwich
- Tolland County—Arthur Sebert  
451 Connecticut Boulevard, East Hartford
- Waterbury Chapter—Edward J. Godfrey, M.D.  
Municipal Building, Waterbury
- Windham County—Napoleon P. Bortolan  
826 Main Street, Willimantic

### Naugatuck Health Survey Planned

Public health surveys will be conducted this coming university year in Darien, Naugatuck and Hartford, Yale's Department of Public Health announced recently.

Department chairman Ira V. Hiscock reported that other surveys recently were completed in Rockville and Vernon. More than thirty such surveys have been made since the first inventories of New Haven and Middletown thirty years ago.

A bill, providing state financial assistance to towns forming health district, was adopted by the 1947 General Assembly. Hiscock said that only a little more than half of the state's population have the benefit of experienced full time health officers.

### Cleveland and Chicago Chosen for AMA

The Executive Committee of the Board of Trustees of the American Medical Association has announced that the mid-winter meeting of the House of Delegates will be held in Cleveland, Ohio, on January 5 and 6, followed by a general scientific session for the general practitioner on January 7 and 8. The Cleveland site was chosen after a careful survey of more than 10 cities in the west and south-west. Cleveland provided the most satisfactory accommodations.

The 1948 session of the American Medical Association will be held in Chicago, June 21-25. The House of Delegates, meeting in Atlantic City recently, voted to hold the 1949 session in Atlantic City and the 1950 meeting in San Francisco.

### Penicillin Therapy for Syphilis in Pregnancy

The effectiveness of penicillin during pregnancy in preventing congenital syphilis is under investigation at the Rapid Treatment Center,\* Bellevue Hospital, New York. Of 149 syphilitic patients treated with penicillin during pregnancy 123 had early infectious syphilis and 26 had latent syphilis. One hundred and fourteen pregnancies resulted in non syphilitic babies and sixteen more (with inadequate follow up) in presumably non syphilitic babies. Ten pregnancies ended in late abortions or premature deliveries, but syphilis was excluded as the cause. There were three cases of congenital syphilis in the group, and there were six late abortions possibly of syphilitic origin. Ninety-four per cent of the entire group had no evidence of syphilitic complications. Two per cent had syphilitic infants and four per cent had difficulties possibly attributable to the disease.

The dosage of penicillin used in the series varied from 600,000 units to 4,000,000 units. Dosages under 2,400,000 are not recommended by the authors. The dosage in current use at Bellevue Hospital is 40,000 units every three hours for 100 doses.

\*Speiser, Mortimer; Flaum, Gerald; Moon-Adams, Dabney; and Thomas, Evan W.: "Penicillin Therapy for Syphilis in Pregnancy," *Journal of Venereal Disease Information* 28: 108, June 1947.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, MRS. ROBERT J. COOK, New Haven

*President-Elect*, MRS. HAROLD W. WELLINGTON, New London

*First Vice-President*, MRS. CHARLES W. GOFF, West Hartford

*Second Vice-President*, MRS. JAMES DOUGLAS GOLD, Bridgeport

*Recording Secretary*, MRS. F. ERWIN TRACY, Middletown

*Corresponding Secretary*, MRS. EDWIN R. CONNORS, Bridgeport

*Treasurer*, MRS. FRANK DiSTASIO, New Haven

#### Summary — Annual Report — Atlantic City, June 9-13, 1947

The Woman's Auxiliary to the Connecticut State Medical Society has been a member of the National Woman's Auxiliary just two years. Our major project has been a program of self-education on the problems confronting the profession. We have stressed the fact that each member has it in her power to help mould public opinion in giving *correct* information on medical subjects and contradicting false statements. The members are becoming increasingly aware of the need for every member to become acquainted with both the scientific achievements of medicine and the economic problems of medical care so that she may pass this information along to her friends and associates. Study groups have been formed with much success. Legislation has been the subject chosen for study. Through the efforts of our chairman *Hygeia* will be used as a supplementary text in the extension courses in health education of all teachers' colleges in Connecticut. A program is going forward to put *Hygeia* in the secondary schools. A friendly spirit prevails throughout every county. This is the basis of a successful organization and good Auxiliary work.

We are making haste slowly. You never heard of a two year old setting the world on fire but she could start a bonfire. Connecticut has started a sizable bonfire which is burning with a steady flame, symbolizing the progress it is making in becoming a part of the vital educational program of American medicine.

Ethel Gray Gold,  
*Retiring President*

#### The National Convention

The business meetings of the National Auxiliary lasted two days. Registration reached a new high this year, there being a total actual registration of

2,205. It was interesting to meet the national officers, Mrs. Hamer of Arizona, the retiring president, the new president, Mrs. Eustace Allen of Georgia, and the president-elect, Mrs. Luther Kice of New York, who has been for some years the chairman of Legislation. The reports indicated an excellent growth in membership and activity, the number of County Auxiliaries now being 726, and the membership well over 36,000, and increasing daily.

The real highlight of the meeting, in my opinion, came in the reports, abbreviated though they had to be, of the State chairmen. The supplying of material for high school debates on medical legislation, gifts of subscriptions of medical publications to the members of the State Legislature, the distribution of pamphlets and the use of the radio in public relations programs were some of the activities in which the States had been engaged during the past year.

In Oregon, the members of the State Medical Society decided to include their wives' dues with their own, which is an effective way of reaching 100 per cent membership in the Auxiliary. In Indiana, a one-day health exhibit was arranged for everyone, dressed up with the title "Health for Glamour." Several of the State Auxiliaries hold meetings with other women's groups, putting on health programs jointly with such organizations as the Federation of Women's Clubs and Parent-Teacher Associations. In some States honorary membership in the Auxiliary is given to women outstanding in the medical and health fields; in others, medical school scholarships have been supplied to promising students. The study of prepayment medical care plans and the dissemination of information about these has occupied much of the time of the Public Relations Committees in various States. It is interesting to hear that the numbers covered by voluntary plans have increased from 1942 to 1946, from 700,000 to 5,000,000.

Two recommendations adopted by the Conven-



tion in this connection were that each State Auxiliary have a chairman of Medical Care Prepayment Plans, and that study groups be active on this subject, so that the members may have information on plans current or suggested, not only in their own State but in others.

Considerable discussion was held on the matter of members-at-large, who may live in a County not large enough to support a County Auxiliary, and it was suggested that in such a case, such members-at-large have a chairman appointed by the State organization, and that all material intended for County presidents go to the members-at-large.

The luncheon speaker on the first day was Miss Lucille Petry, director of the Bureau of Nursing in the United States Public Health Service. She gave us a vivid picture of the shortage of nurses, and her analysis of the various types of nursing service which will have to be developed in order to supply the needed care throughout the country.

On the final day of the Convention, the guest speakers were the officers and Advisory Board members of the American Medical Association, and they gave a picture of the medical situation in the country, the points of weakness and the lack of adequate medical care in certain parts of the United States, with the work to be done to remedy the situation as well as the public relations task of both organizations.

The exhibits on display in the Convention Hall of the A.M.A. were of the greatest educational value and showed graphically the tremendous strides which modern medicine is making.

Edith Valet Cook, *President*

### Hartford County

The first board meeting of the officers and chairmen of standing committees of the Woman's Auxiliary to the Hartford County Medical Association was held on June 17 at the home of Mrs. Paul W. Tisher, president, New Britain. A delicious luncheon was served at 1:00 P. M. A business meeting followed at which time plans were formulated for the year 1947-48. The news letter to be sent out in September to all members of the County Auxiliary will give detailed information concerning the Fall Meeting of October 28, 1947.

### New Haven County

A board meeting of the Woman's Auxiliary to the New Haven County Medical Association was held

Tuesday afternoon at 2:30 o'clock, June 24, at the home of the president, Mrs. H. Freeman Pennington of Williams Street, Meriden.

Reports from the officers and committee chairmen were read and the assistants to the chairmen of standing committees were appointed.

Mrs. Pennington read a report on the activities of the other county auxiliaries and gave a very interesting resume of the meetings at the National Auxiliary convention in Atlantic City, which was held June 9-13 in conjunction with the centennial celebration of the organization of the American Medical Association.

Members of the board who were present in addition to the hostess were Mrs. Arthur H. Morse, Hamden; Mrs. Lewis C. Foster, Hamden; Mrs. Paul W. Vestal, Woodbridge; Mrs. George G. Fox, Meriden; Mrs. John H. Foster, Waterbury; Mrs. Ralph W. Nichols, New Haven; Mrs. Edward R. Smith, Meriden; Mrs. John H. Bumstead, Hamden; and Mrs. Barnett P. Freedman, New Haven.

### Windham County

At the last board meeting of the Woman's Auxiliary to the Windham County Medical Association, it was voted to support the project for Mental Hospitals recommended by the State Auxiliary.

### New York Publishes Woman's Auxiliary Journal

The Woman's Auxiliary of the Medical Society of the State of New York has inaugurated a new publication, called *The Distaff*. This is a quarterly journal, the first issue of which appeared in April. The mailing list includes 2,400 auxiliary members. The editor of the first number is Mrs. Bradford F. Golly of Rome, New York.

### E.M.I.C. Ends

The emergency maternity and infant care program of the U. S. Children's Bureau ended on June 30 with a record of 1,421,000 cases completed or approved for care from March 1943 to June 30, 1947. Over \$124,900,000 had been allotted to the States to cover the cost of the program. Connecticut's record under this program is 13,400 maternity and 4,225 infant cases authorized and \$2,009,720 of Federal funds allotted since May 1943 when Connecticut's plan was approved.

July 14, 1947

## CORRESPONDENCE

*In view of the fact that Dr. Terhune, in addressing the Woman's Auxiliary recently, asked for an expression of ideas we are pleased to publish the following letter from a member of the Auxiliary.—Ed.*

Woodbridge, Conn.  
Amity Road,  
July 10, 1947.

To the Editor:

I read "The Doctor's Wife" with a feeling that there must be some mistake. I could easily imagine that a Reverend Doctor had written it for Godey's Lady's Book in 1847, but Dr. William Terhune, writing it for the CONNECTICUT STATE MEDICAL JOURNAL in 1947? Almost unbelievable!

We who have had any contact with the medical profession, and with psychology and psychiatry, in particular, have often deplored the incorrect, oversimplified and misleading things we have read in women's magazines and in so-called escape literature. But I can think of few which have seemed to me as utterly unrealistic as this analysis of a doctor's wife.

Doctor's wives, like other wives and other human beings vary in physical make-up, mental capacity and emotional stability. Does Dr. Terhune, with his long experience, seriously believe they can all "adapt to life, immediately, completely and gracefully?" Or that they, as a group, should be expected to, by the simple alchemy of becoming doctors' wives?

Can he truly expect any basic good to be accomplished by banning such a harmless, feminine indulgence as the use of perfume?

These are but two random examples of Dr. Terhune's arbitrary concept.

I hope the JOURNAL will provide other interpretations of the doctor's wife for us who are eager to believe that there are standards, and even ideals, inherent in our position, but are unable to feel that flesh and blood women could successfully follow those set by Dr. Terhune's Paper Doll.

Sincerely,  
Ina Vestal

To the Editor:

The Community Advisory Service Center, 258 Golden Hill, Bridgeport, Connecticut, is intimately concerned with the welfare of its disabled veterans and particularly its seriously disabled veterans who are confined to their homes (homebound). Also, our community recognizes and accepts its responsibility to adequately care for these men in the days, months and years ahead. Our program for the disabled represents their resolve that these men shall not be forgotten.

In order to insure this purpose we require the help of your medical colleagues who can be of invaluable assistance. We know there are homebound veterans in the community not known to us and we also know that there will be others in the future. The majority of these men will be under private medical care. If their physicians would notify us of any homebound veterans there is much we can do to help them.

We shall value the cooperation of your doctors and shall gladly discuss our plans beforehand so they may approve or disapprove and perhaps advise us as to how we may be of greater service. We are interested in all veterans but our concern is limited by territory to the following communities: Bridgeport, Fairfield, Stratford, Easton, Trumbull and Monroe.

Thank you for any assistance you and your many associates may offer.

Sincerely,  
Raymond J. McEnerney,  
Coordinator of Disabled Veterans Affairs

### Information Desired

Information is desired as to the whereabouts of David Van Petten who is described as age 17; height 5 feet, 8 inches; weight 125; brown hair, hazel eyes; even white teeth; complexion badly blemished. This boy left the New Mexico Military Institute where he was a student in April 1947. It is believed possible that because of a severe case of acne which affected his general attitude and which may have had some relation to his leaving school, he may from time to time consult a physician.

Information concerning his present or recent whereabouts should be transmitted to the Office of Pinkerton's Detective Agency in Hartford.



## SPECIAL NOTICES

### ANNUAL MEETING OF AMERICAN ROENTGEN RAY SOCIETY

More than 1,000 medical specialists in x-ray and radium are expected to attend the 48th annual meeting of the American Roentgen Ray Society which will be held at Haddon Hall in Atlantic City, September 16-19, 1947. It will mark the ninth time that the society has gathered there since its founding.

President Raymond C. Beeler, M.D., of Indianapolis, Indiana, announced that the Caldwell lecture this year would be delivered on Tuesday evening, September 16, by Dr. Merrill C. Sosman, Boston, professor of radiology of Harvard Medical School.

Dr. Sosman, who is past president of the American Roentgen Ray Society and an intimate friend of the late Dr. Harvey Cushing, will lecture on "Cushing's Disease—Pituitary Basophilism."

The Caldwell lecture, established at the 1920 meeting of the society in Minneapolis, is given annually in memory of Dr. Eugene Caldwell, of New York, who gave his life to the science of medicine and radiology. He died in 1918 from metastatic carcinoma originating from his early unprotected exposures to x-ray. In spite of this handicap and suffering, he was on active duty with the Army Medical Corps at the time of his death, doing research on his stereoscopic fluoroscope.

Three interesting symposia have been arranged for the four day meeting by Dr. Ralph S. Bromer, of Philadelphia; Dr. W. Walter Wasson, of Denver, and Dr. U. V. Portmann, of Cleveland.

Dr. B. R. Kirklin of the Mayo Clinic, Rochester, Minnesota, will be in charge of the Instructional Courses to be offered each afternoon during the meeting.

An interesting scientific exhibit has been arranged by Dr. R. A. Arens of Chicago.

The social program includes a golf tournament on Monday and a banquet and entertainment on Thursday evening.

### ANNUAL CONVENTION OF AMERICAN HOSPITAL ASSOCIATION

The forty-ninth annual Convention of the American Hospital Association will be held Monday, September 22, through Thursday, September 25, in St. Louis, Missouri. More than 7,000 persons are expected to attend.

"Major Factors Affecting the Hospital Economy" will be the subject for the opening general session Monday afternoon. Speakers will include John H. Hayes, New York City, association president; R. O. D. Hopkins, New York City, executive director of the United Hospital Fund of New York; Alvin E. Dodd, New York City, president of the American Management Association, and Leon H. Keyserling, Washington, D. C., economic adviser to President Truman.

Special events planned for the Convention include a buffet supper and informal reception Monday night, presentation of honorary memberships and the award of merit Tuesday night, the annual meeting of the House of Delegates and Assembly Wednesday night, and the annual banquet and ball Thursday night.

Graham L. Davis of Battle Creek, Michigan, director of hospitals, W. K. Kellogg Foundation, will be installed as president of the Association Wednesday night after election of new officers by the House of Delegates.

Dr. Henry H. Crane, pastor of Central Methodist Church, Detroit, will speak at the Thursday evening banquet.

The Award of Merit will be presented Robin C. Buerki, M.D., director of the hospital of the University of Pennsylvania and dean of the University's Graduate School of Medicine. Dr. Buerki, past president of the American Hospital Association and long a leader in hospital progress, will be the ninth man to receive the Award of Merit, which is the highest honor the Association can bestow.

Recipients of honorary memberships will be Capt. J. E. Stone of England, a leader in British hospital work; Thomas S. Gates of Philadelphia, former chairman of the Commission on Hospital Care; Supreme Court Justice Harold H. Burton of Washington; and U. S. Senator Lister Hill of Montgomery, Alabama, co-sponsors of the Hospital Survey and Construction Act.

Regular sessions of the Convention will be broken into four sections on Professional Practice, Administrative Practice, Hospital Planning and Plant Operation and Special Aspects of hospital administration. The four sections will convene simultaneously, and each session will be devoted to one broad aspect of hospital problems and new developments in the hospital field. Thursday afternoon's final general session will consist of a resume of discussions in all special sessions.

General topics slated for special consideration at the various sessions include: raising standards of medical practice in large and small hospitals; Blue Cross contract rates, the Hospital Survey and Construction Act, government hospitals, personnel management, care of psychiatric patients, children's hospitals and pediatric units, nursing and nursing education, trustee-administrator relations, care of the chronic and tuberculosis patient, purchasing, public relations and hospital costs.

Outstanding hospital administrators and experts from related fields will give the principal talks, with panel discussions and audience participation discussions to complete each meeting.

### 1947 SALMON LECTURES

Dr. Harold Dwight Lasswell, internationally known political scientist, has been named the Salmon Lecturer for 1947 by the Salmon Committee on Psychiatry and Mental Hy-

giene of The New York Academy of Medicine. His lectures, titled "The Dynamics of Power and Personality," will be delivered on Wednesday, Thursday, and Friday evenings, November 12, 13, and 14 in the New York Academy of Medicine, 2 East 103rd Street, New York City. Members of the medical profession and their friends are invited to attend.

### THE NEW YORK ACADEMY OF MEDICINE

2 East 103 Street

#### The Twentieth Graduate Fortnight

October 6 to 17, 1947

#### DISORDERS OF METABOLISM AND THE ENDOCRINE GLANDS

The Program includes Morning Panel Discussions, Afternoon Clinics, Evening Lectures, Scientific Exhibits and Demonstrations

##### EVENING LECTURES

October 6—Opening Address—George Bachr, President, The New York Academy of Medicine

The Ludwig Kast Lecture—The Diseases of Adaptation, With Main Emphasis Upon Hypertension—Hans Selye, Institute of Experimental Medicine and Surgery, University of Montreal

The Carpenter Lecture—Adaptation Syndrome In Man—John S. L. Browne, McGill University Clinic of the Royal Victoria Hospital, Montreal

October 7—Energy Metabolism In Obese Persons—Louis H. Newburgh, University of Michigan Medical School

Psychological Aspects of Obesity—Hilte Bruch, College of Physicians and Surgeons, Columbia University

October 8—Relation of the Adrenals to Immunity—Abraham White, Yale University

Clinical and Experimental Studies on Adrenal Cortical Hyperfunction—Louis J. Soffer, Mount Sinai Hospital

October 9—Metabolic Consequences of Immobilization—John E. Deitrick, Cornell University Medical College

Use of Androgens in Women—Ephraim Shorr, Cornell University Medical College

October 10—Studies in Intermediary Metabolism Conducted With the Aid of Isotopic Tracers—DeWitt Stetten, Jr., Harvard University Medical School

The Excretion of Urinary Steroids in Health and in Disease—Konrad Dobriner, Sloan-Kettering Institute for Cancer Research

October 13—Disturbances in Electrolyte Metabolism in Man and Their Management—Daniel C. Darrow, Yale University School of Medicine

Role of Amino Acids in Nutrition—William C. Rose, University of Illinois

October 14—Metabolic Functions in Old Age—Nathan Shock, U. S. Public Health Service, Baltimore City Hospital

General Aspects of Cushing's Syndrome—E. C. Reifenshtein, Jr., Sloan-Kettering Institute for Cancer Research of the Memorial Hospital Cancer Center

October 15—Hormonal and Chemical Factors Regulating Thyroid Function—Rulon W. Rawson, Harvard University Medical School

Some Clinical Experiments With Antithyroid Compound—Edwin B. Astwood, Joseph H. Pratt Diagnostic Hospital, Boston

October 16—Testicular Dysfunction, Some Clinical Aspects—E. Perry McCullagh, Cleveland Clinic, Cleveland

Use of Androgens In Men—Carl G. Heller, University of Oregon Medical School

October 17—Why Do Women Abort—Arthur T. Hertig, Harvard University Medical School

Morphological Basis for Menstrual Bleeding—Joseph E. Markee, Duke University

Registration fee—\$5.00.

A program will be mailed to every Fellow of the Academy without request and to other physicians upon request. Address request to Dr. Mahlon Ashford, 2 East 103 Street, New York 29, N. Y.

### MEDICO-LEGAL CONFERENCE AND SEMINAR FOR PATHOLOGISTS, MEDICAL EXAMINERS AND CORONERS

October 13-18, 1947, Harvard Medical School, Boston

The Department of Legal Medicine of the medical schools of Harvard, Tufts, and Boston University in association with the Massachusetts Medico-Legal Society will present a six-day program of lectures, conferences, and demonstrations having to do with the investigation of deaths in the interests of public safety. Attendance will be limited to 25 persons who have registered in advance.

Further information may be obtained from the Department of Legal Medicine, 25 Shattuck Street, Boston, Mass.

### INSTRUCTIONAL COURSE IN ALLERGY

The American College of Allergists has announced that its annual Fall Graduate Instructional Course in Allergy will be given in Cincinnati, Ohio, November 3-8 inclusive, under the auspices of the Medical College of the University of Cincinnati.

The program this year is the best ever offered by the College. Forty-six formal lectures are listed and also a special allergy clinic of case presentations. An added feature this year will be three informal discussion groups led by various members of the faculty.

The faculty is composed of more than forty outstanding physicians and scientists from prominent medical centers and colleges in the United States and Canada. The course presents a comprehensive study of the entire field of allergy—covering the fundamentals, special allergies, specific diseases, and all modern methods of treatment. Symposia on dermatologic and pediatric allergy are also included, as well as a survey of the laboratory approach to the subject including preparation and standardization of extracts and skin testing.

The course is recommended to all those especially interested in allergy, and to the general practitioner and specialist who anticipates treating his own allergic patients. It is designed to provide a more comprehensive understanding of the many manifestations of allergy so commonly encountered



by the doctor, and to emphasize methods of diagnosis and treatment so that the physician is prepared to offer the greatest aid to his patient.

Programs and complete information can be obtained by writing to the College Secretary, Dr. Fred W. Wittich, 423 La Salle Medical Building, Minneapolis 2, Minnesota.

### NATIONAL SOCIETY FOR THE PREVENTION OF BLINDNESS

The National Society for the Prevention of Blindness announces that it will hold a three-day conference, April 5, 6, and 7, 1948 at the Hotel Radisson, Minneapolis, Minn. This conference will be of interest to persons who are directly or indirectly concerned with eye health and safety. Details concerning the program may be obtained by writing directly to the Society at 1790 Broadway, New York 19, N. Y.

### THE AMERICAN COLLEGE OF PHYSICIANS ANNOUNCES ITS ANNUAL SESSION AT SAN FRANCISCO APRIL 19-23, 1948

The American College of Physicians will conduct its 29th Annual Session at San Francisco, April 19-23, 1948. General Headquarters will be at the Civic Auditorium. Dr. William J. Kerr and Dr. Ernest H. Falconer, both of San Francisco, are the co-chairmen for local arrangements and the program of Clinics and Panel Discussions. The President of the College, Dr. Hugh J. Morgan, professor of medicine at Vanderbilt University School of Medicine, Nashville, Tennessee, is in charge of the program of Morning Lectures and afternoon General Sessions.

Secretaries of medical societies are especially asked to note these dates and, in arranging meeting dates of their societies, to avoid conflicts with the College Meeting, for obvious mutual benefits.

### AMERICAN ASSOCIATION FOR THE STUDY OF GOITER

The American Association for the Study of Goiter will meet in the King Edward Hotel, Toronto, Canada, May 6, 7, and 8, 1948.

The program for the three day meeting will consist of papers dealing with goiter and other diseases of the thyroid gland, dry clinics and demonstrations.

### RESEARCH FELLOWSHIPS—THE AMERICAN COLLEGE OF PHYSICIANS

The American College of Physicians announces that a limited number of Fellowships in Medicine will be available from July 1, 1948—June 30, 1949. These Fellowships are designed to provide an opportunity for research training either in the basic medical sciences or in the application of these sciences to clinical investigation. They are for the benefit of physicians who are in the early stages of their preparation for a teaching and investigative career in Internal Medicine. Assurance must be provided that the applicant

will be acceptable in the laboratory or clinic of his choice and that he will be provided with the facilities necessary for the proper pursuit of his work.

The stipend will be from \$2,200 to \$3,000.

Application forms will be supplied on request to The American College of Physicians, 4200 Pine Street, Philadelphia 4, Pennsylvania, and must be submitted in duplicate not later than November 1, 1947. Announcement of the awards will be made as promptly as is possible.

### INTERNATIONAL SHORTWAVE CONGRESS

The sixth international shortwave congress will be held in Amsterdam from July 19-24, 1948.

Those who wish to take part in the congress are requested to communicate with me for further information.

Colleagues, who wish to give a lecture or an address on the congress, in connection with this science, (therapy, biology or physics) are requested to apply early and to send in the manuscript before April 15, 1948 at the latest, to colleague W. F. K. Gouwe, Lutten-Dedemsvaart Holland, so that the contents can be inserted in time in the report of the Congress.

Dr. J. Samuels,  
Weteringschans 73, Amsterdam, Holland

### MEDICAL PUBLICATIONS NEEDED OVERSEAS

As a result of war and persecution, doctors, dentists and technicians in allied fields throughout Europe have been deprived for more than ten years of news of the latest developments in their professions—the kind of news and analysis contained in this journal.

When you have finished this issue, put it to work by sending it to the SOS (Supplies for Overseas Survivors) Collection of the Joint Distribution Committee, 1539 Troy Avenue, Vanderveer Park, Brooklyn, N. Y. It will be placed in a library in a D.P. camp, child care center, hospital or school, for use by professionals desperately anxious to bring themselves up-to-date on the knowledge forcibly kept from them by the Nazis.

### THE HEBREW MEDICAL JOURNAL Volumes I and II, 1946, New York

*Harofe Haivri* (The Hebrew Medical Journal) which is dedicated to the continued growth of Hebrew medical literature, has concluded its nineteenth year of successful publication, under the editorship of Moses Einhorn, M.D., of New York.

The medical section of Volumes I and II, 1946 contain the following articles: "Renal Lithiasis and its Treatment" and "Urinary Tract Infections" by Abraham Hyman, M.D., "The Menopause, an Endocrine Dysfunction" by Raphael Kurzrok, M.D., and "The Present Conception of the Treatment of Anemias" by Gershon Ginzburg, M.D.

Under the heading of Palestine and Health, Ch. Berlin, M.D., and N. Lass, M.D., offer two interesting surveys on prevailing skin and allergic diseases in Palestine. Dr. T. Ashkenazi writes on hygiene and sanitation among the Bedouins.

## OBITUARY

James L. Moriarty, M.D.

1871 - 1947

James L. Moriarty was born in Norwich, Connecticut, attended Norwich Free Academy and received the degree of M.D. from Harvard Medical School. He came to Waterbury in 1896 and practiced there until 1946. In his early days in Waterbury he had a very extensive general practice. He was of an exploring nature and studied exhaustively.

Dr. Moriarty owned the first x-ray machine in the city of Waterbury. He continued working with x-ray up until 1926. In those days it was the custom to test the voltage of the x-ray by passing one's hand in front of the tube. Because he had a feeling that such a practice might have a deleterious effect on the tissues of the hand, he was more fortunate than some of his contemporaries. However, he did develop a slight pigmentation on the dorsum of the hands, but several of his contemporaries in Waterbury eventually lost fingers and later died from the effects of x-ray. When St. Mary's Hospital opened in 1908, Dr. Moriarty furnished the x-ray room and the entire x-ray equipment. He also was in charge of this department of the hospital for several years.

He became attendant orthopedic surgeon at the Waterbury Hospital around the turn of the century, and also became the attendant orthopedic surgeon at St. Mary's Hospital when it opened in 1908.

On October 17, 1917 Dr. Moriarty entered the United States Army and was assigned to the British Army and stationed at the Second Northern General Hospital where he did orthopedic work under the command of Sir Robert Jones. At this station he also came in close contact with Sir Berkely Moynihan. During the tour of duty with the Army he learned of the death of his only son, James. Both he and Mrs. Moriarty, all their lives, felt this loss very deeply.

Dr. Moriarty resumed civilian practice in May 1919. From that time on he limited his practice to orthopedic surgery. In continuing his studies Dr. Moriarty made five trips to Europe—1913, 1917, 1922, 1924, and 1929—visiting clinics in England, France, Switzerland, Italy, Ireland and Germany. He came in contact with such men as Putti of Italy.

Up until 1938 he attended the yearly meetings of the American College of Surgeons. He was a member of the Waterbury Medical Association since 1899, and also was a past president of the Connecticut State Medical Society.

Dr. Moriarty was an exceptional orator. He delivered papers and in discussing papers of others was very resourceful and could quote freely all the authorities in his field. Had he not been in the practice of medicine Dr. Moriarty might have become very successful on the stage. At Harvard he belonged to the Hasty Pudding Club, and in Waterbury during the early part of the century he belonged to the Acme and Talma Clubs. He took part in many of Gilbert and Sullivan operettas, and there are those who can testify to the excellent quality of his performances.

Dr. Moriarty was a very kind man, and many of the early interns speak of the interest he showed in them and in their work.

In 1938 he had a very serious illness which was nearly fatal. After recovery he carried on in his field with determination. In December 1946 he retired from practice and purchased a home at Wildemere Beach where he continued to keep up his interest in medicine and current events.

John H. Dillon, M.D.

Harold J. Cleary, M.D.

Patrick J. Brennan, M.D.

## NEWS

### *from County Associations*

#### Fairfield

E. Everett Rowell, member of the Stamford city council and former local health officer, died July 13 after a long illness. Dr. Rowell served as roentgenologist at St. Joseph's Hospital, Stamford, and at hospitals in Greenwich and Norwalk. He was also an ardent golfer and an enthusiastic horseman.

The Annual Summer Outing of the Bridgeport Medical Association was held at Eichner's Grove in Bridgeport on July 9. About one hundred members enjoyed a day and evening of relaxation. Many of the members enjoyed golf at neighboring courses



in the afternoon, while others engaged in baseball and horse shoe pitching. Dinner was served at seven o'clock and extraneous activities under the able direction of B. J. Burns followed. Dr. Burns whose efforts in making these affairs such a huge success was assisted by the Outing Committee consisting of Drs. B. L. Smykowski, George A. Buckhout and Edward L. Kemp. Everyone who attended admitted to a very enjoyable recess from the rigors of medical practice.

The Fairfield County Golf Association held their July meeting and tournament at the Greenwich Country Club on the twenty-third. Twenty members engaged in the tournament at this beautiful course and enjoyed an excellent dinner at the Club in the evening. Prizes were awarded to the lucky golfers with the lowest scores and a meeting of the handicap committee followed the dinner at which time scalpels were wielded for the good of the future tournaments. Dutch Wehger was in rare form and his accuracy was only excelled by his Hoyle approach. Grady Booe was so enthralled with the Greenwich scenery he explored the glorious country declined by the United Nations and came home by way of Brewster and Danbury. The members are indebted to the efforts of Dr. Robert Hansell of Greenwich for the enjoyable afternoon and evening.

Members present at the outing were glad to welcome John O'Connell home after his recent illness and sojourn in Florida. John looks his healthy jovial self again. Charles Gardner has been enjoying a three weeks vacation at Lake Mohonk in New York State, and reports that the fishing was good and is exhibiting his blue ribbons won in putting contests. George Buckhout and his family have taken to the wilds of Maine for their summer vacation. Edward P. Kemp was appointed to the office of treasurer of the Bridgeport Medical Association to serve out the term of the late Jimmy Walsh.

Edward F. McGovern, M.D., has been appointed school physician for Fairfield, to serve until the establishment of a health department for the town. Under the terms of Fairfield's new charter, a Board of Health will be created, and this board will appoint a school physician some time in October. Prior to his residence in Fairfield, Dr. McGovern was in the government service. He succeeds Dr. Stephen V. Pastor, who resigned last spring after completing his tenth year as school physician.

## Litchfield

Howard S. Allen, M.D., of Woodbury died on July 5. Dr. Allen was medical examiner and health officer in Woodbury where he had been a practicing physician for forty-one years.

## Middlesex

The annual report of the Middlesex Hospital has been received and graphically shows what we already know, namely that the hospital is constantly overcrowded, understaffed and noticing the rising costs. This report also notes the addition of several new doctors to the staff.

The hospital has acknowledged a gift of a Wappler Surgical Unit from the Middletown Exchange Club in memory of Luke V. Seagriff, a former president and actively interested in hospital affairs.

The Medical Board has contributed over a thousand dollars and established a Fauver Scholarship Loan Fund for the use of deserving members of the nursing school classes. This is made possible for student loan scholarship.

On a recent fishing trip off Montauk, Long Island, Floyd Minor caught two "school tuna" much to the envy of Willard Buckley, Jim Vinci and Dick Grant who were apparently along for the ride.

## New Haven

Simon B. Kleiner of New Haven has been elected a Fellow of the American Proctologic Society. This Society was organized in 1899 and its membership is limited to 100 Fellows.

## Tolland

Harry H. Moore, M.D., a practicing physician in Stafford Springs for nearly half a century, died recently at the Hartford Hospital after an illness of several months.

## Windham

*Cancer of the Rectum, an Analysis of Cases Occurring in Connecticut during 1935-1945* by Edward J. Ottenheimer, M.D., was published in *The New England Journal of Medicine*, July 3, 1947.

Having been elected a Fellow of The American Psychiatric Association at a recent meeting of the Committee on Membership, Olga A. Little, M.D., of Willimantic, will now be entitled to the use of the initials F.A.P.A., following her name. Dr. Little is now a member of the Active Staff at the Windham Hospital in Willimantic.

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## News from Yale University School of Medicine

### Gift of \$2,500 Given Yale Medical School

At its 24th annual meeting held recently in Farmington, the Planned Parenthood League of Connecticut, through its president, Mrs. Roger Howson of Taunton district, donated \$2,500 to the Department of Obstetrics and Gynecology of the Yale University School of Medicine. Dr. Herbert Thoms, representing the school, received the gift, which is to be used to further the work of the School of Medicine's infertility clinic. This is the second of three such gifts to be presented by the League, the first having been made a year ago, and the third committed for presentation early in the summer of 1948.

## NEW BOOKS IN REVIEW

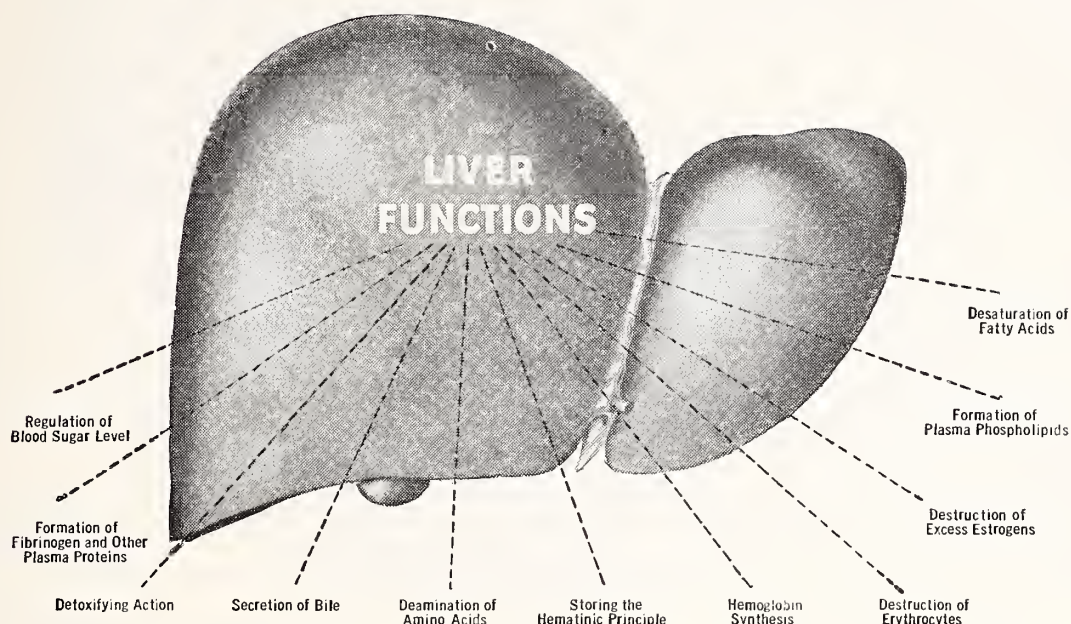
*THE ECHO.* By Lilla Van Saher. New York: E. P. Dutton & Co. 1947. 255 pp. \$2.75.

Reviewed by RICHARD KARPE

Freud apologizes to his readers that the reports of his treatments, his case histories, sound like novels, but that he found it unavoidable if he wanted to do justice to his cases. On the other hand we have learned to read some novels like case histories. Psychoanalytic case histories and novels seem, therefore, to have something in common. A new novel written by Lilla Van Saher attempts to put the psychoanalytic treatment in the center of the story.

The author is the daughter of an Hungarian philosopher, and the sister of an outstanding psychoanalyst. She studied medicine, later became a model, and actress. Only recently, after her immigration to the United States she became a writer. It is to the literary critic to judge whether she succeeded in writing a good novel. The psychoanalytic reviewer is asked whether the treatment described gives a correct picture. The author certainly proves that she has a very good knowledge of the forces which are uncovered in psychoanalytic treatment. She says about the psychoanalyst in her novel, Dr. Carl Huisen, that he is a member of the International Psychoanalytic Association. This reviewer would recommend him only reluctantly for a psychoanalytic treatment. The first job of the psychoanalyst is to listen and, only after he understands what he has listened to, will he give his explanations to the patient. Dr. Huisen does not always act that way and offers sometimes explanations before he has learned enough from the patient. These explanations have to be repeated and modified on the basis of





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new facts uncovered in the analytic treatment. The single interpretation does not produce the miracle that we would hope for. Because of this process of "working through," analysis takes such a long time. It may seem to the reader that the 210 hours of the analysis, which is the span of the novel, should be long enough for the treatment of one patient. In real practice, it still would be considered a short treatment. Although the author calls the treatment a success, this reviewer looks doubtfully at the results.

The story, shortly, is that: A young French woman, married to a successful physician twenty years her senior, finds herself discouraged about the difficulty she has in adjusting herself to the requests of her husband. She would like to love him, but she feels an estrangement as soon as he is physically close to her. On a visit to her parents she gets suddenly involved with the stableboy and discovers feelings in herself unknown to her in her relationship with her husband. She confesses her flirtation. After months of marital friction they separate.

Visiting friends in Holland, she is half persuaded and half

decides for herself to undertake psychoanalytic treatment. The diagnosis given her is: acute emotional disturbance with neurotic trends. It would be more correct, however, to consider the acute emotional disturbance secondary to the neurotic personality structure. Nineteen out of twenty-two chapters contain the description of the psychoanalytic treatment. This treatment leads to a successful termination in less than a year in spite of great resistances which are quite skillfully described. During her analysis she becomes engaged and disengaged until she becomes involved with an anti-fascist. This involvement is considered by her and the author the "real love." She becomes absorbed in the Dutch underground movement and decides to take part in the fight against the Germans. Because of political conditions she sees very little of her new lover. Her new participation in political events is also considered her cure. The story and the treatment ends before we learn more about the further development of her new relationship.

This attempt to put psychoanalytic treatment in the center of a novel certainly deserves our attention and our inter-

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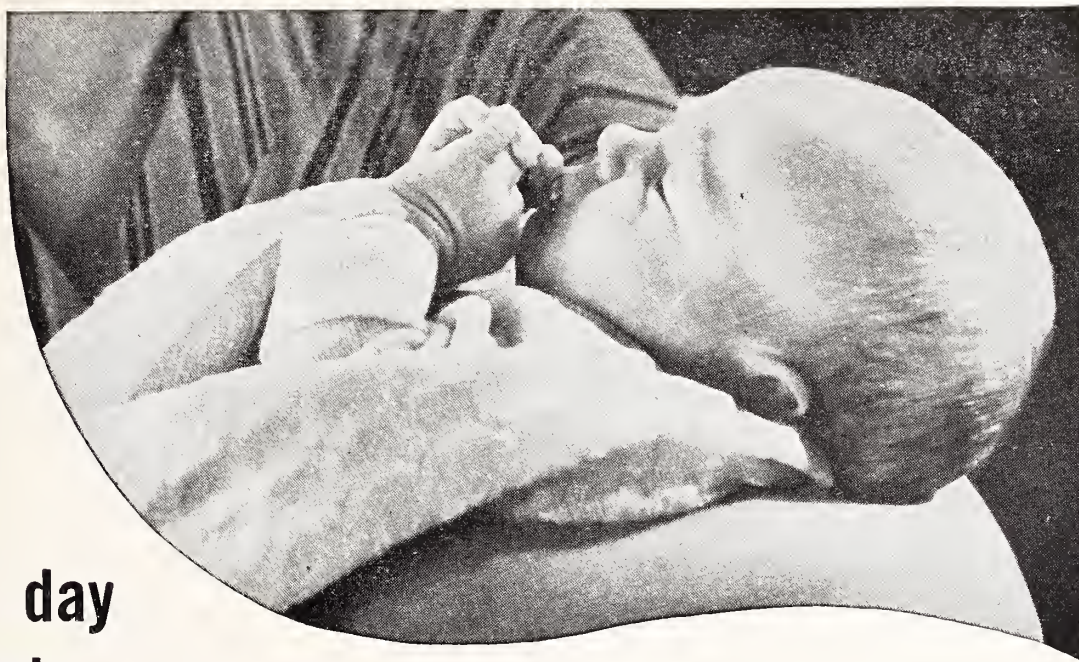
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\*Vital Statistics—Special Reports: Vol. 25, No. 12, National Office of Vital Statistics, Washington, D. C. (Oct. 15) 1946, p. 206.

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est, perhaps even our gratitude. This novel should not be used as a substitute for a scientific description and discussion of the psychoanalytic method.

**HANDBOOK OF DIET THERAPY.** (Second impression 1947.) *Written and Compiled by Dorothea Turner for The American Dietetic Association. Chicago: The University of Chicago Press. 112 pp. \$2.00.*

Reviewed by MARY E. TANGNEY

This handbook has been sectioned carefully into four distinct divisions, namely Normal Diet, Adaptations of the Normal Diet for Therapeutic Purposes, Interviewing the Patient, and an Appendix comprised of useful tables on food analyses and ideal body weight.

The writer devotes fifteen pages to normal diet, and then, using the normal diet as a basis, she allows thirty-five pages to explain how the normal diet should be modified to accommodate therapeutic prescriptions for special diets. This correlation between normal and therapeutic diets is sensible and time saving.

Since the volume is a handbook, the writer does not elaborate on the patient's mental or physical reaction to special diets except for one instance. The section on interviewing the patient, which is definitely directed to dietitians, excellently brings out the significance and value of interviewing, but it would be of even greater value had it offered concrete suggestions for mastering some techniques for this procedure.

The book is thoughtfully and carefully compiled, and it should serve as a practical and worthwhile reference not only to dietitians, but also to physicians and nurses who frequently are called upon to write therapeutic diets.

**CLINICAL ELECTROCARDIOGRAPHY.** (Second Edition.) *By David Scherf, M.D., F.A.C.P., Associate Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals, and Linn J. Boyd, M.D., F.A.C.P., Professor of Medicine, New York Medical College, Flower and Fifth Avenue Hospitals. Philadelphia: J. B. Lippincott Company. 1946. 267 pp. \$8.*

Reviewed by H. M. MARVIN

This volume has much to commend it to the beginner and to the more advanced student and practitioner. It is more comprehensive than one might expect in a volume of only 260 pages, for the pages are large and are printed in two columns. Some hint of its scope is given by the titles of the three main sections: "Theory and Methods," "Alterations of the Ventricular Complex and their Significance," and "Disturbances of Stimulus Formation and Conduction." There are nearly 250 illustrations, many of the figures containing from two to eight electrocardiograms. With the exceptions mentioned below, almost every aspect of this complex subject is discussed fully and authoritatively.

From the standpoint of the present reviewer, one of the most laudable features of the book is the author's constant insistence that electrocardiograms are often only a small part of the total picture, and should always be interpreted in the light of all other available clinical and laboratory evidence. The reader is constantly brought back to this fundamental

consideration, and is repeatedly reminded that conspicuous alterations in the main or terminal deflections of the ventricular complex often have no *specific* significance, but may be caused by several or many different conditions, some of them lying outside the heart. In these days when so many young and untrained practitioners own electrocardiographs and confidently make diagnoses of "coronary disease" or "myocardial damage" without justification, and without the slightest comprehension of the great limitations of the method, it is refreshing to find these authorities insisting upon a consideration of the entire clinical picture and a recognition of the fact that the electrocardiograph is merely an additional laboratory instrument.

The text is not restricted exclusively to a discussion of electrocardiograms, but in the case of arrhythmias is extended to include treatment also. Most of this reflects current views, but some of it would encounter objections from experienced clinicians. The small doses of quinidine, for example, which the authors recommend seem to the present reviewer quite inadequate for many conditions; his use of much larger doses for twenty-five years has provided no basis for fear of the drug. In fact, it is probably correct to say that quinidine is usually given in inadequate dosage, rather than in amounts that are too large. References to the intravenous injection of this drug seem to imply that this is an easy and simple procedure, but actually there is no solution available commercially, and it is difficult to prepare.

In several respects the book is very disappointing. Most of these find an explanation in the fact that the text and illustrations appear to have been prepared some years ago, and not in 1945 or 1946 as the publication date would seem to indicate. The illustrations, with very few exceptions, are of curves taken with the older type machines which had oscillating or vibrating time markers, and a number of them are poorly reproduced; they do not compare favorably with the beautifully clear electrocardiograms to which American readers are accustomed. However, with very few exceptions, they illustrate adequately the point for which they were selected. A more serious fault, and one which it is difficult to condone, is the almost complete absence of precordial leads. Aside from the very brief chapter on chest leads, only 16 figures contain even one precordial lead, and the one selected is invariably CR 2. It is more than surprising to find that the entire chapter dealing with the exercise test in the diagnosis of coronary stenosis contains only three electrocardiograms of patients with this condition, and not one of these has a single precordial lead, which is currently regarded as the one most important lead in such tests. The chapter on chest leads is far from adequate, in view of the large amount of work in this field in recent years. Very few illustrations are given, and only two include two precordial leads. The authors have arbitrarily chosen the CR leads as the most satisfactory, without stating their reasons. They make no reference to the Wilson leads which employs a central terminal with a fixed resistance, or to later modifications of this. They do state that "it seems best" to record from two precordial points rather than from the apex alone, and designate positions 2 and 4 as preferable, although it is now known that no one or two points will always yield the full information that can be derived from further exploration. This chapter is sadly out of date.



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<sup>1</sup>Reh fuss, M. E., *The Ulcer Life*, Clinics 3:480-493 (Oct.) 1944

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There is an extensive bibliography of more than 600 titles, placed appropriately at the ends of chapters or sections. It is an excellent selection from the vast literature up to 1940, but contains only 15 references after this date; 10 of these 15 are to papers written by the authors of the book under discussion.

It would be misleading to leave the impression that the book's faults outnumber and outweigh its merits, for the reverse is true. The reviews of the basic physiology and pathology, the summaries of past work, the broad appraisal of electrocardiography, and the interpretations of curves in the light of the whole clinical picture, are admirable, enlightening, and sound. There is scarcely a page that does not reveal clearly the extensive experience of the authors in the experimental laboratory and in the hospital wards. It is unfortunate that these features, which are of immense value, are not supplemented and strengthened by a text and illustrations that are up to date.

**PRACTICAL EMULSIONS.** (Second, completely Revised Edition, including a symposium on *Emulsifying Agents and Emulsions in Industry*). By H. Bennett, Technical Director, Glyco Products Company, Inc.; Editor, *Commercial Waxes, Chemical and Technical Dictionary, Chemical Formulary*, etc. Brooklyn, N. Y.: Chemical Publishing Co., Inc. 1947. 568 pp. \$8.50.

Reviewed by E. L. McCawley

There is little material in this book that has a direct bearing on the practice of medicine. Two brief sections dealing with lecithin as an emulsifying agent and surface active agents as germicides do, however, contain material of general medical interest, material difficult to find in other sources.

For those engaged in industrial medicine or in research the book is an excellent source. It is usually difficult to obtain the chemical composition of tanning agents, cutting oils, agricultural sprays, and other emulsions used in industry which may, of course, cause allergic or irritant reactions. Almost one half of the book is devoted to formulas of every kind of emulsion. Sufficient detail is presented so that one not already familiar with emulsions may duplicate useful preparations; yet the inclusion of new procedures and formulae would be of interest to the expert in the field.

The book is clearly written and easy to read. It lists 2,869 references to general and patent literature, but its usefulness would be increased by a more complex index.

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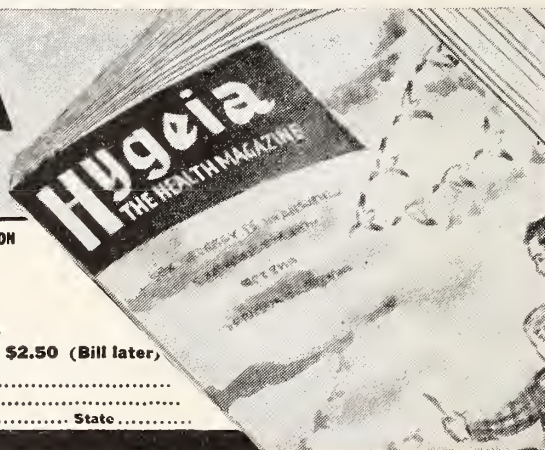
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# INDICATIONS FOR THORACOLUMBAR SYMPATHECTOMY IN ADVANCED ESSENTIAL HYPERTENSION WITH END RESULTS OF OPERATION IN 375 CASES

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THE END results of operation are especially important in a disease with such a poor prognosis as advanced essential hypertension. While the internist is reluctant to refer early cases for operation, which would naturally give more lasting end results, he is quite willing to refer advanced cases for operation. Our experience has been with advanced cases almost exclusively, and therefore the operative mortality is higher than in the earlier cases. It is very important to the surgeon and the internist to have clear-cut indications for accepting or rejecting these advanced cases for operation. It is our feeling that death occurring six months postoperatively indicates an unwise selection of patients for thoracolumbar sympathectomy. The only exception to this rule is the case in which papilledema has produced total blindness, and operation is performed to restore vision. Even when this objective is attained, it must be understood by the patient and his family that life expectancy will not be changed by this procedure.

In a previous report<sup>1</sup> we reviewed 227 thoracolumbar sympathectomies done over a period of four years, and from our studies of these cases we obtained information of real value in selection of advanced cases for operative procedure. Unfortun-

nately we did not follow these criteria during the following year. If we had done so, the results we are presenting today would be more favorable. These 375 cases were completed two months ago. Since then we have adopted a system of rules which are being adhered to, resulting in a higher rejection of cases for operation, and an operative mortality of zero.

Our grouping includes four organs, namely, the eyes, the cerebrum, the heart and the kidneys, using the rating 0 to plus 4, according to the extent of disease of each organ (Table 1). This is based on Keith, Wagener and Barber's grouping of eye ground changes.<sup>2</sup> From our observations, a plus total of 8 is the danger signal in considering a case for thoracolumbar sympathectomy.

Operation is indicated in all cases in which there is no contraindication rule. From the viewpoint of minimal involvement operation is probably advisable for patients with persistent hypertension associated with definite though minimal objective changes in any one of the four systems.

Contraindications to thoracolumbar sympathectomy are:

- 4 plus renal
- 4 plus cardiac in which congestive heart failure is unremitting, or if coronary occlusion occurs within three months
- 4 plus cerebral if confusion exists or if a stroke occurs within three months

*Presented at the 155th meeting of the Connecticut State Medical Society, Hamden, April 30, 1947*

TABLE 1  
RULES FOR EVALUATION OF SYMPTOMS IN INDICATIONS FOR OPERATION

SYMBOLS USED		EYES	CEREBRUM	HEART	KIDNEYS
0		Normal	No symptoms or signs	No symptoms or signs	Normal
1+		Arteriolar narrowing	Headaches and/or dizziness and nervousness	Slight symptoms and/or slight enlargement and slight E. K. G. changes	Nocturia; but concentration 1.024 or more; urea clearance 75% or more
2+		Arteriolar narrowing and arterio-venous nicking	Headaches and/or nosebleeds and/or occipital headaches and/or dizziness and nervousness	Moderate symptoms and/or moderate x-ray enlargement, moderate E. K. G. changes	Urea clearance 40-75% concentration 1.015-1.023
3+		Arteriolar narrowing and arterio-venous nicking and hemorrhages and exudates	Headaches and/or nosebleeds and/or occipital headaches and/or dizziness and nervousness and parasthesias	Marked symptoms and/or marked enlargement and marked E. K. G. changes	Urea clearance less than 40%; concentration less than 1.015; normal blood chemistry
4+		Arteriolar narrowing and arterio-venous nicking and hemorrhages and exudates and papilledema	Stroke or encephalopathy or confusion	Coronary occlusion or congestive heart failure	Persistent elevation of N. P. N. to 45 mgm. or more and B. U. N. to 25 mgm. or more

If there are two 4 pluses other than eyes

If the total plus count equals 11 or more.

If we had adhered to these rules in consideration of these 375 cases we would have rejected 25 patients who were accepted for operation and followed over a period of six months. There were 38 deaths, including two suicides after leaving the hospital. If we had followed our rules, 30 of these deaths would have been excluded. On this basis, then, the number of cases accepted for operation should have been 320, and the operative mortality 8, or 2.5 per cent.

Occasionally the application of these rules works a hardship in an individual case, but it is sound for the over-all selection of cases. The following case illustrates the exception.

A man, 34 years of age was totally disabled, with severe headaches and papilledema. On admission in June, 1943, blood pressure was 290/155 but under sodium amytal it dropped to 165/105. He had a plus total of 11. Operation was performed on June 22, 1943 and on July 8, 1943. In October of that year the patient returned to work and has been asymptomatic ever since then, and working regularly. On June 25, 1945 the blood pressure was 180/115; on September 19, 1946, 250/150; and on March 26, 1947, 240/140. On his last visit the patient stated that he felt perfectly well and was working regularly. As shown in the slide, the papilledema had entirely disappeared three weeks after operation.

Table 2 presents subjective and objective improvement following thoracolumbar sympathectomy in selected cases of advanced hypertension. It will be noted that the subjective and objective evaluations are very similar.

TABLE 2  
SUBJECTIVE AND OBJECTIVE END RESULTS OF OPERATION

NO. OF PATIENTS	FOLLOW-UP PERIOD (MOS.)	IMPROVEMENT			
		SUBJECTIVE		MARKED AND MODERATE OBJECTIVE IMPROVEMENT*	
215	6	163	76%		
148	12	123	83%		
76	18	62	81%		
62	24	50	80%		
152	6			123	81%
69	12			62	90%
31	18			28	90%
15	24			11	73%
8	36			8	100%

\*This evaluation is based on postoperative blood pressure; electrocardiographic readings, heart x-ray, blood chemistry, urinalysis, and symptomatic improvement.

Smithwick<sup>3</sup> has emphasized the importance of a narrow pulse pressure in obtaining a good postoperative result in essential hypertension. Our results as shown in Table 3 are contrary to his findings. Smithwick<sup>4</sup> has emphasized that patients with a hospital diastolic pressure of 140 and above do not respond satisfactorily to a thoracolumbar sympathectomy. In 24 males with a diastolic pressure of 140 or higher



TABLE 3

RELATIONSHIP OF PRE-OPERATIVE PULSE PRESSURE TO THE ONE YEAR OPERATIVE RESULT IN 164 PATIENTS

DIASTOLIC PRESSURE 110—			DIASTOLIC PRESSURE 110+		
	93	57%		71	43%
Pre-op type I	21	22%		17	24%
II	31	78%		25	76%
III	41			29	

TABLE 4

104 PATIENTS WHOSE DIASTOLIC PRESSURE EXCEEDED 150 MM. HG.

Dead			22
Hospital		13	12.5%
H-V-D		9	
3-11	8		
18	1		
Follow-up			82
0-6 Mos.		36	
12		39	
24		17	
Inc. or Proc.		2	
Lost		5	

MEAN POSTOPERATIVE DIASTOLIC PRESSURES

FOLLOW-UP	ONE YEAR	TWO YEARS
Resting	123 mm. (39 points)	129 mm. (17 points)
Exercise	117 mm. (35 points)	121 mm. (15 points)

TABLE 5

72 HYPERTENSIVES AGED 50-59 YEARS SUBJECTED TO SYMPATHECTOMY

Dead				11
Hospital		4	5.5%	
H-V-D		7		
3-6 months	2			
7-12	3			
18-24	2			
Lost				3

SUMMARY OF 58 LIVING PATIENTS

FOLLOW-UP (MOS.)	6	12	24	30	36	48
Patients	10	33	12	1	1	1
Resting	6	60%	20	60%	8	66%
110—						
Diastolic						
Exercise	9	90	20	60	7	58
110—						
Diastolic						

he reports 20 deaths, 3 slightly improved, and 1 markedly improved. The results in our cases in this category are in variance with Smithwick's findings, as shown in Table 4.

De Takats et al<sup>5</sup> have emphasized the importance of operation in patients under 40 years of age having a diastolic pressure not exceeding 120 mm. of mercury. Our experience with the older age group would seem worth recording (Table 5).

End results of thoracolumbar sympathectomy cannot be properly evaluated without a discussion of the extent of the operative procedure. The minimum operation in this series of 375 cases included 9 thoracic ganglia through the 2nd lumbar ganglion with removal of the greater, lesser and least splanchnic nerves, which represents about half the cases reported. The operative procedure since then has been much more extensive. In about 20 cases we have included the Stellate ganglion through the third lumbar ganglion and all the splanchnic nerves. The operative procedure, as we now do it should include the 3rd thoracic ganglion through 3rd lumbar ganglion with all the splanchnic nerves. It is obvious that the more radical the operation the higher the mortality, but also the better end results.

COMMENT

As yet no method for selection of patients for operation in essential hypertension has been found which is satisfactory in all cases. After all studies have been considered, including eye grounds, E. K. G.s, 6 foot heart plate, x-rays, intravenous urograms, urea clearance, concentration tests, blood chemistry and sodium amytal and Etamon tests, the decision must still rest to a very definite extent on clinical judgment.

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ANALYSIS OF THIRTY-FOUR CASES OF CARCINOMA OF THE RECTUM AND RECTOSIGMOID TREATED BY ONE STAGE COMBINED ABDOMENOPERINEAL RESECTION, AT THE WATERBURY HOSPITAL, 1940 TO 1946, INCLUSIVE

CLARENCE H. COLE, M.D., *Waterbury*

THIS PAPER is a study of thirty-four cases of cancer of the rectum and rectosigmoid operated upon at the Waterbury (Connecticut) Hospital from 1940 to 1946 inclusive. In these cases, a one stage combined abdomenoperineal resection of the rectum has been done on the premise that it is the surgical procedure of choice, offering the best chance for cure for the disease under consideration. It is felt that this operation compares in therapeutic efficiency with other radical surgical procedures for cancer elsewhere as in radical mastectomy for carcinoma of the breast and total gastrectomy in advanced carcinoma of the stomach. This study is made in an attempt to evaluate our results and modify our procedures in the future as indicated. It is scarcely necessary to add that the operative procedure employed is that of Miles of London, who along with other followers have established its therapeutic soundness.

It is true that a series of thirty-four cases it not statistically significant, however, it is necessary to re-evaluate one's material at intervals in order to determine where he stands. C. W. Mayo reported (S.G.O. 1943, 76.649-654) a mortality of 14.2 per cent in his first 105 combined abdomenoperineal resections. As a result of changes in preoperative care, in the procedure itself, in anaesthesia and post-operative care, in the following 171 cases in which the same operation was performed, there were only two post-operative deaths. Consequently, the analysis resulted in a reduction of the mortality by 13 per cent.

In this hospital, these operations have been performed by ten different surgeons, all but one of whom are members of the surgical or gynecological staff. The case incidence by years follows:

*Presented at the Connecticut Association of Tumor Clinics, Waterbury, February 20, 1947*

TABLE 1

YEAR	NUMBER	MALE	FEMALE
1940	1	1	0
1941	5	3	2
1942	4	3	1
1943	5	2	3
1944	5	3	2
1945	7	6	1
1946	7	5	2
Total	34	23	11

The average age of the entire group was 56.8 years.  
The average age of the males 60.5 years.  
The average age of the females 50.5 years.

TABLE 2

Average age of group	56.8 years
Average age of males	60.5 years
Average age of females	50.5 years

TABLE 3

CASE INCIDENCE BY DECADES

30-40	3 cases
40-50	7 cases
50-60	10 cases
60-70	11 cases
70-80	1 case
80-90	2 cases
Total	34 cases

The number of days in the hospital before operation was performed varied considerably, however, twenty cases were ready for the major procedure at the end of seven days, most of this time being required for the biopsy pathology report. Ten more cases were ready at the end of fourteen days, and the four remaining cases required an average of 27.6



days, the longest being in the hospital forty-four days before operation.

The tumor was palpable on rectal examination in thirty instances. Proctoscopy and biopsy were done on twenty-three cases, sigmoidoscopy and biopsy were done in three cases. Biopsy was done in four other cases as reported in the tumor clinic record but not reported on the patient's hospital chart. It is probable that these four biopsies were done in the physician's office. In all, thirty biopsies were done. In four cases the gross appearance of the tumor alone was used as indication for the major procedure and the malignancy was confirmed by the operative specimen.

The classical symptoms of cancer in this region are blood or bleeding in the stool, change in bowel habit, abdominal cramps or pain of an obstructive nature. These, along with the late symptom of weight loss were reported as follows:

TABLE 4  
ANALYSIS OF SYMPTOMS

			LAHEY CLINIC 1945
Rectal bleeding or blood in stool	30 cases	88.2%	86.0%
Change in bowel habit	28 cases	82.5%	79.0%
Cramps or pain	15 cases	44.1%	7.0%
Loss of weight	17 cases	50.0%	—

In the majority of instances the bleeding was described as bright red in character and in one case the only symptom noted was the onset of rectal hemorrhage. Of the twenty-eight patients who noted change in bowel habit, eighteen reported diarrhoea, eleven constipation and in three both diarrhoea and constipation were present.

A previous history of regional disease occurred as follows: hemorrhoids nine cases, colitis (type unspecified) two cases, and rectal fistula, one case.

Loss of weight when recorded varied from four to twenty-five pounds and in nine cases where the amount was specifically noted the average was 12.6 pounds.

In only one case was the family history positive for previous malignancy in which the patient's father died of an unspecified tumor.

The period of delay from the onset of symptoms until the first physician visit varied from five days to eighteen months, as follows in the twenty-four cases indicated:

TABLE 5

PERIOD OF DELAY	CASES
1 week	2
1 month	2
2 months	4
3 months	3
6 months	4
12 months	6
18 months	3

The initial blood count noted on admission to the hospital varied from 5.9 million R.B.C., 118 per cent Hbg. to 2.6 million R.B.C. 50 per cent Hbg.

In nine cases the R.B.C. was reported from 5 million R.B.C. 98 per cent Hbg. to 5.9 million R.B.C. 1118 per cent Hbg. probably due to dehydration.

The R.B.C. 4 to 5 million—18 cases  
3 to 4 million—3 cases  
2 to 3 million—2 cases

In practically all instances, the color index was approximately 1.0.

Such a major surgical procedure as we have under discussion should not be employed unless the bowel has been well prepared and emptied. Usually the patients were prepared with saline catharsis and in certain instances the patients had been given a pre-operative course of sulfaguanidine.

Some surgeons have sent their patient to the operating room with an indwelling catheter which is to remain in place postoperatively until the bladder regains its tone. It goes without saying where anemia, dehydration or cardiac complication existed, these conditions were treated appropriately over a relatively short time so that the surgical procedure was not contraindicated. In the majority of instances the patient's reserve had been evaluated by the usual laboratory tests, namely; C.B.C., urinalysis, blood sugar, N.P.N. determinations. In certain instances electrocardiograms were done. Where indicated patients were transfused and in all cases blood was in reserve for transfusion at operation or post-operatively.

Since 1942 continuous spinal anesthesia has been employed supplemented with pentothal where necessary. In only one case was avertin, nitrous oxide and ether used. Prior to 1942, nitrous oxide was used instead of pentothal. During the anesthesia an infusion and in most cases a transfusion also was given. The operative procedure employed was essentially that recommended by Miles. Usually a left paramedian exploratory incision was made to estab-

lish the operability of the lesion. The operative notes indicate metastasis to the liver in two cases. In five cases the pathologist reported metastasis to the regional lymph nodes.

Postoperatively the patients care consisted of general measures, such as infusion, transfusion, and the administration of oxygen either in the tent or by B.L.B. mask. As would be expected in a group of patients approximately half of whom are in the sixth decade, the need of post operative cardiac support is commonplace. Early post operative ambulation is not indicated in procedures of this magnitude. However, it is not unusual for these patients to be gotten out of bed on the tenth or twelfth day and out of the hospital in approximately three weeks.

In the early postoperative period and during the period of hospitalization it is essential that the physicians and nurses in attendance assist the patient in his adjustment to his colostomy. In this series there is one striking example of a patient's failure to adjust himself to the situation which resulted in his suicide in the hospital seventy-five days after operation.

The care and dressing of the colostomy, the abdominal and perineal wounds, although an essential consideration in the recovery of the patient, will not be discussed here as material of this nature is difficult to elicit from the clinical charts of the various surgeons.

In determining the operative mortality, we have included all of the postoperative deaths which occurred in the hospital.

Hence, five patients died within the first postoperative week, representing a mortality of 14.7 per cent. The sixth death, a suicide by drowning in the hospital on the seventy-fifth postoperative day raises

TABLE 6  
CLASSIFICATION OF TUMORS

TOMOR TYPE	NUMBER OF CASES			AVERAGE AGE	
	TOTAL	MALE	FEMALE	MALE	FEMALE
Adenocarcinoma,					
Grade 1	4	4		65.2	
Grade 2	23	17	6	59.4	52.8
Grade 3	5	2	3	60.	43.6
Squamous Cell Carcinoma,					
Grade 2	2		2		46.5

TABLE 7  
CLASSIFICATION OF DEATHS

NAME	AGE	SEX	COMMENTS
P. D.	62	M	Expired seventh postoperative day. Heart failure.
A. B.	70	M	Expired second postoperative day. Heart failure.
M. D.	65	M	Expired day of operation. Shock.
O. F.	83	M	Expired second postoperative day. Cardio-vascular failure. Shock.
A. M.	39	F	Expired third postoperative day. Intra cerebral hemorrhage.
L. D.	58	M	Suicide seventy-five days after operation in hospital.

the mortality to 17.6 per cent. Autopsy of this case failed to show any evidence of extension or recurrence of the original cancer.

Thus it is seen that to date, nine of the twenty-eight postoperative survivals have died of recurrence, 32.1 per cent. One other died of heart failure at thirty-one months after operation without gross evidence of recurrence or metastasis.

Of the remaining eighteen patients now living the cases are distributed as follows according to the year in which they were done.

TABLE 8  
DEATHS SINCE DISCHARGE FROM HOSPITAL

NAME	SEX	YEAR	AGE	TUMOR GRADE	P.O. LENGTH OF LIFE	CAUSE OF DEATH
P. P.	M	1940	52	2	20 months	Recurrence
F. J.	F	1941	47	2	58 months	Recurrence
J. C.	M	1941	63	1	31 months	Heart failure
S. H.	M	1941	55	3	8 months	Recurrence
E. J.	F	1942	52	3	3½ months	Recurrence
B. F.	M	1942	37	2	3 months	Recurrence and hemorrhage
A. A.	F	1943	45	3	31 months	Recurrence and lung metastasis
J. H.	F	1943	47	Sq. C. Gr. 2	8 months	Recurrence
T. B.	M	1943	53	3	21 months	Diffuse metastasis
F. C.	F	1944	62	2	16 months	Recurrence and metastasis



TABLE 9  
SURVIVALS BY YEARS

YEAR	CASES DONE	LIVING
1940	1	0
1941	5	2
1942	4	2
1943	5	2
1944	5	3
1945	7	4 one recurrence 14 months
1946	7	5

# SUMMARY AND DISCUSSION

The average age of the thirty-four cases was 56.8 years, male 60.5 and female 50.5 years. Twenty-one or 61.7 per cent occurred between 50 to 70 years of age. The tumor was palpable rectally in 30 or 88.2 per cent cases. Twenty cases were biopsied and ready for operation at the end of one week and only four cases required more than two weeks preparation. Thirty biopsies were done preoperatively. The classical symptoms, rectal bleeding and change of bowel habit were noted in over 80 per cent of these cases.

Weight loss noted in 50 per cent of the patients is evidence of advanced disease and this along with the reported periods of delay indicate that at least half of the lesions were advanced before examined by the surgeon.

The initial blood count was over 4 million R.B.C. in twenty-seven cases or 79.4 per cent.

Since there have been several operators, the evaluation of specific points of technique or procedure would be difficult. Some surgeons used sulfaguandine preoperatively, but recently this appears to have been discontinued. Some prefer the patient with an indwelling catheter during the operation which is useful in identifying the urethra in the prostatic portion of the dissection. It also keeps the bladder decompressed during the procedure. No ureteral catheters were employed during the operation in any of these cases. Some surgeons ordered indwelling catheters postoperatively.

Although most preferred a left paramedian or midline exploratory incision a right paramedian incision was used in a few cases. The care of the colostomy warrants discussion but little is included in the records to enlighten this point. Some tied a large rectal tube into the colostomy stoma at the end of the operation. Others leave the colostomy clamped off for twenty-four or forty-eight hours depending upon the patient's general condition and the degree of abdominal distention.

Some have sutured the mesentery of the sigmoid colon to the abdominal wall to prevent herniation of small bowel around it with subsequent strangula-

TABLE 10  
ANALYSIS BY YEARS OF CASES NOW LIVING

YEAR	NAME	SEX	GRADE	OPERATIVE AGE	NUMBER OF MONTHS SINCE OPERATION	COMMENTS
1941	L. L.	M	2	62	74	No recurrence
1941	A. O.	F	2	56	63	No recurrence
1942	A. C.	M	2	56	55	No recurrence
1942	C. H.	M	2	61	50	No recurrence
1943	E. H.	F	2	59	44	No recurrence
1943	W. F.	M	1	45	40	No recurrence
1944	L. T.	M	2	63	32	No recurrence
1944	M. B.	F	Squamous Cell 2 CA	46	20	No recurrence
1944	G. C.	M	2	80	37	No recurrence
1945	S. D.	M	2	46	11	No recurrence
1945	J. C.	M	2	63	13	Recurrence reported
1945	J. R.	M	2	69	22	No recurrence
1945	E. P.	F	3	36	21	No recurrence
			2	55	9	No recurrence
1946	E. B.	F				Hysterectomy for CA 1928
1946	F. M.	M	2	67	2	No recurrence
1946	P. W.	M	2	59	10	No recurrence
1946	J. P.	M	2	60	6	No recurrence
1946	A. A.	M	2	63	9	No recurrence

tion. C. W. Mayo was specific on this point (S.G.O. 1943, 76:649-654) stating that he closed small openings and left large ones open. Suture nothing under tension.

Continuous spinal anesthesia with pentothal has been the anesthesia of choice.

Approximately two-thirds or 67.6 per cent of the tumors were adenocarcinoma grade 2. The postoperative mortality including a suicide on the seventy-fifth postoperative day is 17.6 per cent; omitting the suicide the corrected mortality is 14.7 per cent.

There have been nine deaths or 32.1 per cent due to recurrences with an added death due to heart failure. At present, eighteen cases or 64.2 per cent are living with one case of recurrence fourteen months after operation.

C. W. Mayo feels that the following points have improved his results, reducing his mortality in 171 cases to 1.17 per cent.

1. Admit 48 hours before operation.
2. Avoid unnecessary delay on operating table.
3. Urethral catheter in place.
4. Well cleansed bowel (phosphosoda, enemata).
5. Estimation of patient's reserve and combating debility, anemia and dehydration.
6. Mental preparation for colostomy.
7. Antiperitonitis vaccine given two days before operation as a therapeutic adjunct.
8. Use of spinal anesthesia, pentothal and oxygen.
9. Use of transfusion during operation.
10. A thorough understanding of the surgical team of the operative details employed from start to finish.
11. Left paramedian incision used.
12. Exploration—
  - (a) Gross metastasis is contraindication.
  - (b) Five per cent cases also show cancer of abdominal colon.
  - (c) Obesity or small degree of metastasis to liver—no contraindication.
13. Adequate incision.
14. Long scissors are an advantage.
15. Complete as much of the rectal dissection from above as possible.
16. Rectal tube is sutured to the colostomy opening.

17. Perineal portion done from lithotomy position without removal of the coccyx.

18. Sulfanilamide and a posterior pack is used for four days to support the pelvic floor and control bleeding.

19. Postoperative care—

(1) General. (a) Transfusion of 500-1000 cc of blood. (b) All patients get oxygen tent or B.L.B. mask at least 24 hours.

(2) Ambulation—Dangle eighth day. Out of bed ninth day. Sitz bath tenth day. Discharge in three week. 80-85 per cent of cases.

20. Avoid fecal contamination of wound as long as possible.

Lahey in 1945 (*Lahey Clinic Bulletin* 1945, Oct. 162-166) reported cancer of the rectum as being resectable in 83 per cent of cases with an operative mortality of 3.8 per cent in the rectum with a 50 per cent, five year non recurrence rate. These figures, however, are derived from screened cases which have been considered operable in the majority of cases before going to the clinic. Lahey pointed out that the operability and non recurrence rates in the average run of cases in the average general hospital must be much lower. He made a plea for early recognition and diagnosis on basis of attention to the cardinal symptoms, i.e., blood in stool, altered bowel function, and abdominal cramps or pains. He states that failure to investigate the colon by barium enema, contrast enema and sigmoidoscopic examination will fail to improve the present status of these lesions. In the Lahey Clinic a 3 per cent incidence of polypi in the rectum and colon is found and they feel that an improvement in the diagnosis and management of the polyps would materially diminish the incidence of colonic cancer.

Regardless of the size or gross appearance of the lesion, Lahey feels that practically all cases should be explored to determine operability.

#### CONCLUSION

An analysis of the data taken from thirty-four cases of one stage combined abdominoperineal resection of the rectum and rectosigmoid has been presented.

It is apparent that in many of the cases the diagnosis has been surprisingly and unjustifiably late due principally to failure of the patient to heed the warning of the early symptoms of cancer of the colon. The mortality rate in this series of cases 17.6



per cent is high and should be capable of very great improvement. Better results in this field require that every general practitioner, physician and surgeon improve his diagnostic skill to get the cancer case early. Little can be offered a far advanced malignancy in any region.

It goes without saying that the surgeon must be experienced and in this type of case operate with a definite logical plan, passing from stage to stage in an orderly, progressive, well executed manner. Hesitancy, inexperience, lack of foresight, indecision, poor preparation, poor team work or delay, may be fatal.

CANCER OF THE PROSTATE

C. H. NEUSWANGER, M.D., *Waterbury*

SIX YEARS ago castration and estrogen therapy were added to our inadequate methods of treating cancer of the prostate. Since then conflicting reports have been made about the results of this treatment, but many interesting facts are generally agreed upon. Cancer of the prostate causes difficulty in voiding, nocturia, retention, hematuria and incontinence but so does benign hypertrophy. Blood in the urine is not characteristic of cancer of the prostate. It is for example, much more suggestive of bladder tumor and cases of benign hypertrophy of the prostate will bleed more profusely than those of cancer. Low back pain and progressive loss of weight are fairly characteristic of cancer of the prostate but unfortunately the disease may be far advanced before these symptoms appear.

A ten year survey in Connecticut shows that cancer of the prostate accounts for ten per cent of all cancer in the male and of four and one half per cent of cancer in both sexes. There has been an average of one hundred and forty-eight deaths from cancer of the prostate during the last four years. Seventy-five per cent of cancer occurred between the ages of sixty and eighty in Connecticut during the past ten years but one case was found in a boy age two. Since the tumor clinic started in Connecticut, ninety-four per cent of the cases have had complete follow ups. Most of the other six per cent are those who have moved out of the state.

Of one hundred fifty cases studied in Waterbury, only two were suitable for radical operation. Further progress in treating this disease must come by early diagnosis and this can be accomplished only by routine examination of men of cancer age.

Estrogen treatment is relatively ineffective in benign hypertrophy and it should not be given in

suspected early cases of cancer since it will mask the symptoms and postpone an early diagnosis. Every suspicious nodule of the prostate gland should have a perineal biopsy.

Of seventy-five consecutive cases of cancer of the prostate treated by castration, the symptoms in eight cases were definitely aggravated. All eight of these cases died in from two to fourteen months after operation and clinically this treatment was an obvious failure. Even among cases showing marked improvement for several years the patient eventually became worse, the symptoms returned and despite any treatment the decline and death was rapid. One patient after three years of relative comfort had a recurrence of symptoms in spite of which he maintained an excellent appetite. One afternoon four hours after eating his noon meal he died while sitting in his easy chair. Previous examination had shown his heart and blood pressure to be normal and he gave no appearance of having had an embolus. Unfortunately no autopsy was obtained in this case but in other cases it had been difficult to account for the sudden death which occurs in patients who have had castration and estrogen treatment.

The following table will show the treatment and results obtained in cases treated by castration.

No. of cases castrated.....	75
Metastases demonstrated .....	29
Transurethral operations .....	52
Repeated transurethral operations.....	6
Radical operations .....	2
Castration plus stilbestrol.....	61
Acute retention .....	21
Chief complaint priapism.....	4
Relieved of pain.....	64
Greatest gain in weight.....	72 lbs.
Average gain in weight.....	19 lbs.
Deaths .....	27

Thirty-five of the above cases showed some temporary improvement and clinically their symptoms were not aggravated by castration or estrogen treatment. Thirty-two of these cases were definitely improved. They all showed a definite gain in weight, relief of symptoms and were returned to a useful occupation. Compared to the cases not treated by this method these patients showed a definite increase in length of life.

TREATMENT	NOT CASTRATED	CASTRATED
No. of cases	75	75
Years studied	1933-8	1941-7
Alive after		
1 year	62	70
2 years	32	47
3 years	14	26
4 years	4	10
5 years	2	8
6 years	1	6
Total years lived	200	358

Of these one hundred and fifty cases, none were colored and none were Hebrews. Cancer of the prostate gland has often been reported as of much lower incidence in these two races. The following chart will show a comparison of the incidence of cancer by nationality.

NATIONALITY	PER CENT OF CASES	PER CENT OF POPULATION
American	34	16
Irish	32	14
German	12	7
French	7	9
Swedish	5	6
Polish	4	7
Italian	3	17
Lithuanian	3	11
Hebrew	0	9
Miscellaneous	0	4

Two cases of the second series having old draining sinuses from superpubic operations were permanently healed after castration and the use of estrogens. This result was not before observed in cases of cancer of the prostate. One patient was described by his wife as being impossible to live with. Following castration and estrogen treatment his personality was completely changed, thereafter his wife frequently volunteered the information that their home life was pleasant.

The beneficial effects of estrogen on cancer of the prostate and a comparison of cancer of the genito-urinary tract in the male and female gives one the impression that estrogen may in some way inhibit cancer of the urinary tract.

The following figures show the incidence of cancer in Connecticut for ten years from 1935 to 1945.

	CANCER OF KIDNEY	BLADDER	URETHRA	TOTAL
Male	212	702	15	929
Female	129	278	11	418

CONCLUSIONS

Castration is probably the best treatment in advanced cases of carcinoma of the prostate but ultimately wears out as a cure.

It relieves symptoms and definitely prolongs life in some cases.

It saves hospital and medical care and returns the patient to a useful life.

Early diagnosis by routine physical examination will improve our present treatment.

CARCINOMA OF PROSTATE

Waterbury Hospital 1932 to 1946 inclusive

H. J. STETTBACHER, M.D., *Waterbury*

THIS presentation is a review of the cases of Cancer of the Prostate as listed with the Tumor Clinic Registry of the Waterbury Hospital with particular emphasis on incidence, treatment and survival rates. Our tumor clinic registry was begun in

1931. This report is based on a fifteen year experience.

It will be noted that there has been a very definite increase in the admission rate in each succeeding five year period. This arithmetical increase is attributed



Incidence: Total Tumor cases (1932-1946).....2,465  
Cancer of Prostate..... 134 5.4%

ADMISSIONS	NO.	AGE	AVERAGE
First 5 year period	25	50-80	68
Second 5 year period	45	56-89	69
Third 5 year period	64	52-83	71

to a combination of the following circumstances rather than to an increased incidence of the disease.

1. Diminishing resistance to hospitalization.
2. Increasing longevity of population.
3. Increased radius of hospital coverage.
4. Increasing number of patients electing treatment in their local community.

The diagnosis were established as follows:

Pathological examination of surgical specimens....	87
Needle biopsy .....	2
Clinical and x-ray.....	41
Autopsies .....	4

Of those cases diagnosed by clinical and x-ray findings some 31 occurred in the first two five year periods. During the last five year period there were ten such cases. These were treated with orchiectomy. No surgical treatment of prostate being indicated.

The cancers fell into the following grades:

Grade 1 .....	23
Grade 2 .....	56
Grade 3 .....	5
Not graded .....	9

The following treatment methods were employed:

No treatment .....	12
Transurethral prostatic resection.....	23
Transurethral with orchiectomy.....	20
Transurethral with later orchiectomy.....	2
Perineal prostatectomy .....	5
Perineal with orchiectomy.....	1
Perineal with later cystostomy.....	1
Supra-pubic prostatectomy .....	10
Supra-pubic with orchiectomy.....	5
Supra-pubic with later orchiectomy.....	8
Supra-pubic with later cystostomy.....	1
Orchiectomy .....	10
Orchiectomy with later T.U. resection.....	5

Because transurethral prostatic resections were not done until 1938 and orchiectomy for cancer control not until 1941 the varying treatment methods listed above reflect the forms of therapy employed during the first one half of the 15 year period.

During the last five year period the treatment of carcinoma of prostate has been limited to orchiectomy and hormone therapy, with transurethral pros-

tatic resection being done when indicated for urinary obstruction.

In no cases have radical perineal prostatectomy, x-ray or radium been used with the intent of curing the disease.

X-ray therapy has been used in many cases to relieve the pains of bony or pelvic metastases. The results have varied considerably. In general they have not been satisfactory.

#### SURVIVAL RATES (GROSS)

PERIOD	NO.	DEAD	LIVING	AVERAGE
First 5 year	25 (24)	18 mos.		18 mos.
Second 5 year	45 (40)	25 mos. (5)	70 mos.	28 mos.
Third 5 year	64 (34)	15 mos. (30)	23 mos.	18 mos.

The average survival rate for the last 5 year period is obviously incomplete. It will exceed by many months the 28 month rate of the previous period as there are still some 30 living cases with the following survival rates.

4 years .....	5
3 years .....	3
2 years .....	6
1 year .....	9
Less than 1.....	7

Because orchiectomy and hormone therapy were done only during this last five year period the following survival rate table has been compiled of patients undergoing combined therapy. There are no suitable records of patients given only hormonal therapy.

#### SURVIVAL RATES FOR COMBINED THERAPY

	NO.	DEAD	LIVING	AVERAGE
Third 5 year period	56 (32)	25 mos. (24)	29	26 mos.

It will be noted that in all three categories i.e. living, dead and average there has been a very definite increase in the survival time. To date the average gain is eight months. This, of course, will show considerable increase when the figures for the surviving 24 cases are completed. Forty-six per cent of patients so treated are still living. Important as has been the increase in survival time, our experience is similar to those reporting from other clinics, in that the general well being of the patients so treated has been markedly improved. All patients did not respond equally well. In some few no apparent benefit was noted. But the majority of the patients so treated were relieved of all symptoms, gained in weight and were able to return to their regular activities. This gain has continued for a varying time but when reaction occurred the decline

	AGE	GRADE	TREATMENT	COURSE	SURVIVAL
D. D.	71	Not specified	S.P. Prostatectomy 1936 X-ray Rx 1937 Orchiectomy 1942	Died of disease	96 months
W. M.	79	1	S.P. Prostatectomy 1936 Orchiectomy 1946	Died of disease	84 months
C. A.	67	1	S.P. Prostatectomy 1937	Died of disease	67 months
C. N.	79	1	T.U. Resection 1939 Orchiectomy 1942	Living with disease	66 months
F. R.	67	1	T.U. Resection 1939 X-ray Rx 1940 T.U. Resection 1942 Orchiectomy 1941 Cystostomy 1945	Died of disease	64 months
N. B.	79	1	T.U. Resection 1939 Orchiectomy 1946	Living with disease	74 months
F. C.	71	1	Transurethral Res. 1939 X-ray Rx 1941 Orchiectomy 1942	Living with no evidence of disease	91 months
W. C.	77	1	S.P. Prostatectomy 1938	Died no evidence of disease at	84 89 months
C. G.	76	2	T.U. Resection 1941 Orchiectomy 1942	Living no evidence of disease	64 months
F. C.	73	2	T.U. Resection 1941 Orchiectomy 1941	Living no evidence of disease	64 months

was much more rapid. In some patients the response was truly spectacular. The local growth regressed and not infrequently surgical relief of obstructive symptoms was not necessary. As most of our patients died of the disease combined therapy did not diminish the incidence of metastasis, but seemed merely to retard the progress.

FIVE YEAR SURVIVALS

Of the 134 cases there have been ten five year survivals. Of these four have died of the disease and two are living with the disease slowly progressing. Of these five have had orchiectomy. There are also four other cases, three of whom are living and one dead, which have showed no evidence of recurrence.

Of the cases presented there remain three living five year survivals without evidence of the disease and one with a seven and one half year survival who died of cardiac disease without evidence of disease. This last case had only a supra-pubic prostatectomy. A review of the pathological slides confirmed the

diagnosis. The original studies showed the malignancy to be a nest of cells entirely contained within the central portion of one lobe. As a matter of speculation it may be assumed that if all the 600 odd prostates removed supra-pubically had serial section studies of the gland several other such cases might have been found.

SUMMARY

- 1. Treatment and survival rates of 134 cases of cancer of the prostate have been presented.
- 2. Survival rates have risen since the institution of orchiectomy and hormone therapy.
- 3. Four cases of five year survival without apparent recurrence of cancer are presented.

CONCLUSIONS

Combined therapy (orchiectomy and hormone therapy) in this series of cases of cancer of the prostate has resulted in improved survival rates and in improved palliative results.



## CREAM INJECTIONS AS AN AID IN VISUALIZATION OF THE TRACTS OF FISTULA-IN-ANO

MAURICE LEVINSKY, M.D., and MICHAEL S. POPKIN, M.D., *Bridgeport*

**A** PATHOLOGICAL tract between the ano-rectum and some adjacent viscus or skin surface is called an ano-rectal fistula.

Invariably, all fistulae are preceded by abscess formation, which in turn usually originates from infection entering a crypt situated most often in the posterior half of the anus at the ano-rectal line. Fistulae may extend in any direction and may be single or multiple, but they usually have only one internal opening.

These fistulae represent approximately twenty-five per cent of ano-rectal diseases.

It is now believed by all authorities that the only curative treatment for anal fistulae is surgical, yet recurrences in this condition are only too common.

The cardinal reasons accounting for failure in practically every case of fistulectomy are as follows:

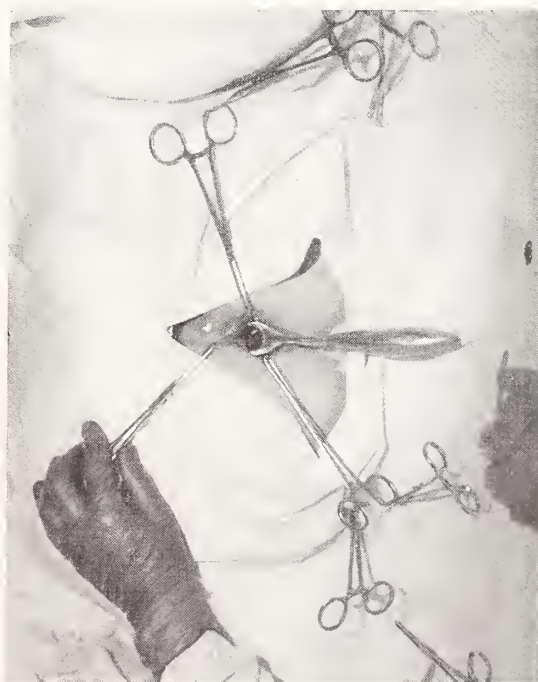
One, failure to find the internal or primary opening; two, failure to trace all tracts to their termini; three, failure to open and excise all tracts and the structures external to them so that these tunnels are converted into open ditches throughout their entire course; and four, faulty post-operative treatment which does not insure that the cavity will heal from within outward.

What has the surgeon done about this?

Operations for anal fistula should begin at the source of the disease, at the internal opening, but most of them are begun at the secondary or external opening and the attempt to trace the tract is started at that point. Some surgeons inject colored solutions or pastes at the start; others insert a probe or grooved director through the secondary opening into the fistulous tract. When this latter procedure



Pilonidal cyst tracts



Cream oozing out of internal fistulous opening

is followed in an attempt to trace a fistulous tract that courses at an angle through the tissues, the wall of the fistula may be perforated and the probe may enter normal tissue without the surgeon being aware of it. The resistance of the fistulous wall and the tissues in which it lies is often so indistinct that it is not possible to determine whether the tract is being followed.

If a probe is used, it should be inserted only a short distance at a time before splitting the fistulous tube. By observing this precaution large portions of normal tissue are not likely to be uncovered unnecessarily, and if the operation is begun at the primary opening, the possibility of missing the point of origin of the disease is eliminated.

Examination of the anal crypt is of utmost importance in connection with anal fistulectomy. Success in discovering obscure portals depends a great deal on the surgeon's ability to recognize pathologic changes in the crypts. However, there are many cases where a visible primary sinus opening is lacking. Other evidences of the primary opening are then sought for, namely; the presence of a discharge or spot of pus on pressure; a scarred area, where healing has taken place may be found; a tuft of granulation tissue may be seen in a crypt presenting evidence of inflammation; one or more of the anal crypts may be deeper than usual; a papilla or several of them may give evidence of hypertrophy, edema, or fibrosis; all indicative of disease.

In order to determine the completeness, multiplicity and extent of these fistulous tracts, as well as the internal opening, various dyes and pastes have been injected through the external opening. Most observers believe that the procedure is very limited. Many dyes have been and still are employed. The most commonly used ones are five per cent aqueous solution methylene blue, saturated solutions of potassium permanganate, iodine, lipiodol, and Beck's paste. The latter consists of bismuth subnitrate, thirty-three per cent and vaseline, sixty-seven per cent and is radio opaque. Lynch uses methylene blue one part and hydrogen peroxide two parts while Newman employs methylene blue in petrolagar. The disadvantages of this procedure are that the dye follows the line of least resistance and often penetrates the wall of the tract, thus escaping into the surrounding tissue and masking its true extent.

Beck's paste omits small branching tracts and frequently clogs the many channels.

For the past two years we have used a cream which has eliminated some of these objections. This cream contains sulfathiazole ten per cent, sulfanilamide ten per cent, and cetylpyridinium chloride two-tenths of one per cent in an oil-in-water base of the vanishing cream type. Through a twenty-gauge needle whose tip has been blunted we have injected through the external opening of twenty-seven fistulae about one half of one cubic centimeter of this cream and in twenty-one of these cases the white cream could be seen oozing through the internal opening within the anal canal.

In those cases where an obstruction was noted we could dissect along the tract, close to its wall, until the internal opening could be reached. Because of the consistency of the cream, even under marked pressure, at no time was a false channel made.

Recently we have used this same cream in injecting the tracts found in many pilonidal cyst sinuses, and it has proven of value in the complete excision of the cavities, since wherever the cyst wall was nicked, the white cream could be seen escaping.

In conclusion we believe that the injection of this cream is an improvement over other dyes and pastes used in the past to help find the internal opening of fistulous tracts, but that recurrences will still take place unless the reasons accounting for the failure in practically every case of fistulectomy are removed. These reasons for the failure in fistulectomy are one, not finding the internal opening; two, not following all tracts to their termini and excising them; and three, faulty after treatment.

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## PHYSIOLOGIC AND ANTIBIOTIC THERAPY OF BRONCHIAL ASTHMA

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THE PURPOSE of physiologic therapy may be described as the attempt to maintain normal activity in an organ whose function has been hampered by disease or adverse environmental influences. In intractable bronchial asthma, or in the more severe state of this illness known as status asthmaticus, profound disorders in the physiologic behavior of the lungs and the bronchi have taken place, at times manifesting themselves in anoxia as well as more complex functional pathology. Physiologic therapy in respiratory disease, which was at first employed to combat anoxemia by inhalation of oxygen, now includes a number of measures that have more or less specific advantages in coping with alterations in the mechanics as well as the chemistry of breathing.

This presentation will consist of a brief review of the pathologic-physiology of obstructive dyspnea, since many of our therapeutic procedures have been outgrowths of investigations in this field, and then an appraisal of recent physiologic and antibiotic methods employed in the treatment of intractable asthma when allergically directed therapy has not been successful in eliminating the cause of the condition. It should be emphasized at the outset that continued inquiry into the possible allergic etiology of asthma should be made in each patient and that attempts to aid the patient from the point of view of allergically indicated measures should be carried out whenever possible. The concept that underlies the form of treatment presented as physiologic therapy is that disturbances in the functioning of the lungs and bronchi need not be allowed to continue untreated when specific measures of therapy

have failed to relieve the symptoms and signs of the disease.

## PATHOLOGIC PHYSIOLOGY OF OBSTRUCTIVE DYSPNEA

When experimental constriction of the trachea is produced, an abrupt and progressive increase in the negative intrapleural pressure during inspiration takes place; this is the critical factor that results in secondary pathology, such as congestion and edema in the bronchi and alveoli, with increasing anoxia and final circulatory failure. Studies have been carried out which reveal that obstruction to expiration alone, with inspiration maintained through a normal lumen, does not produce pathologic changes in the lungs whereas a comparable constriction during inspiration, with the lumen during the expiratory cycle normal, is followed by the characteristic changes such as edema of the dependent parts of the lungs with emphysema at the periphery, swelling of the bronchial mucous membrane due to congestion and edema.<sup>1</sup> These findings have been correlated with the progressive increase in the intrapleural negative pressure.<sup>2</sup> The heightened negative pressure within the lungs during inspiration not only exerts local suction effects on the intrathoracic structures but also aids the inlet of blood into the thorax and retards the exit of blood from the lungs into the heart. As the intrapulmonary negative pressure increases circulatory insufficiency takes place as well as respiratory failure.

In animals with obstructive dyspnea various procedures have been shown to decrease the intrapleural negative pressure in inspiration, i.e. (1) oxygen inhalation, which accomplishes this effect by decreasing anoxia and thereby lowering the pulmonary ventilation; (2) helium with oxygen, which results in ventilation of the lungs at a lower pressure, due to the higher effusion of helium-oxygen mixtures through a narrow orifice in comparison to air or pure oxygen; (3) positive pressure

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breathing, which decreases the suction or negative inspiratory pressure by forcing air or oxygen from the atmosphere into the lungs; (4) administration of broncho-dilator or broncho-vasoconstrictor substances, either by nebulization or systemically, which increases the patency of the bronchial passageway, especially in the presence of spasm of the circular muscles.<sup>2,3,4,5</sup>

#### PHYSIOLOGIC THERAPY OF INTRACTABLE ASTHMA

The measures which have been described above as being of demonstrable help in experimental obstructive dyspnea are frequently employed in the treatment of patients in whom persistent bronchial spasm has been present. The regimen of the individual patient will vary according to the duration and severity of the illness, the degree of functional or organic pulmonary emphysema and other factors. Our presentation will consist in the main of outlining general principles that are applicable to most patients.

In many cases of severe asthma a palliative program which provides effective bronchodilator therapy is both helpful and desirable. Inhalation of nebulized epinephrine 1:100 or 1:75 is generally prescribed on arising, in the late afternoon and at night, as required. If a nebulizer is used which provides particles of relatively small size, the drug reaches the small bronchi and alveoli. In patients in whom inadequate relief is obtained with this method, oral medication is preferable to hypodermic injection of 1:1000 adrenalin. When aminophylline is employed it should be taken on an empty stomach, best results following its ingestion on arising, in dosages of 0.2 and at times 0.3 grams. Ephedrine may be used similarly in a dosage of 0.025 to 0.05 grams. For more effective relief of severe asthma a combination of these drugs with amytal may be prescribed as follows to be taken on arising and, when necessary, between 4:00 and 6:00 P. M.

##### Day capsule:

Aminophylline .....	0.25
Ephedrine .....	0.035
Amytal .....	0.05

Since the stimulating effect of aminophylline and ephedrine results in a wakeful state when taken at night, a slow-acting and a quick-acting sedative may be added, together with extract of belladonna, as follows:

##### Night capsule:

Aminophylline .....	0.3
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Ephedrine .....	0.025
Phenobarbital .....	0.05
Nembutal .....	0.1
Extract of Belladonna.....	0.015

A capsule of this kind should not be taken early in the evening since paroxysm of asthma may not take place until the effects of the drug have worn off; it is, therefore, preferable to defer its use until symptoms have actually arrived, or, if desired for prevention of the attack, at a late retiring hour, such as between 11:00 P. M. and midnight.

The concept of utilizing the cumulative effect of a variety of measures in a concentrated therapeutic approach has been one which we have emphasized in the past,<sup>6</sup> not only for patients who are necessarily confined to a hospital because of urgent dyspnea, but also for others who have intractable asthma in less severe form. Even in patients of the latter type, who are just able to come to the office, a consideration of the probable functional pathology in their bronchi and lungs justifies us in suggesting a program of therapy for a week or ten days that has the purpose of establishing a remission in their disease. A full outline of the methods of bronchial relaxation to be pursued is described in advance. This may include putting the patient to bed, providing nursing care, or its equivalent, and some of the procedures discussed below.

Patients who have intractable asthma have become refractory to epinephrine, manifested by partial and transient relief of symptoms. In some cases intravenous injection of aminophyllin in dosages of 0.25 to 0.5 grams, administered *slowly within an eight minute* period, once or twice a day for a period of one week may break a state of persistent bronchial spasm. A similar objective may be carried out by dissolving 0.5, 0.6 or even 0.7 grams of aminophyllin in 20 to 30 cc. of water and instilling it rectally by means of a catheter and syringe.<sup>6e</sup> The use of aminophyllin has now become so widespread that more and more patients are seen who have become refractory to aminophyllin as well as adrenalin. Our therapeutic aim in this group is to maintain normal pulmonary function, to prevent further functional pathology and to obtain bronchial relaxation by other means than those which the patient has previously employed.

When oxygen is indicated for the treatment of anoxia, a rubber catheter inserted into the nasal or oro-pharynx may be employed with an oxygen flow of 6 to 8 liters per minute as a simple method of



providing an oxygen-enriched atmosphere. The oxygen tent, or a head tent with an injector, may also be used to supply 50 per cent oxygen. The mask is not suitable for long continued administration of oxygen since it is subjectively unpleasant to the majority of patients with bronchial asthma. The mask may, however, be employed for intermittent inhalation of helium-oxygen mixtures, such as for periods of one half to one hour as will be commented on below.

When it has been demonstrated that the patient is refractory to aminophyllin the need for other drugs that produce bronchial relaxation is obviously real. Of these, the most useful in our experience now appears to be demerol administered in dosages of 50 to 75 mg. at 4, 6 or 8 hour intervals as required for a period of 5 to 7 days. In our regimen an initial hypodermic injection of 50 mg. is followed in one hour by either 25 mg. or 50 mg., if relief of dyspnea has not taken place. This drug appears to be far superior to morphine or its derivatives since respiratory depression does not take place. The danger of addiction should be recognized but not over-emphasized since it is a rare sequence in ill patients treated for one to two weeks.

Other forms of inhalational therapy, such as positive pressure breathing, may at times be of remarkable benefit when there is expert technical supervision, as in the use of the positive pressure hood. At the present time demand valve mask apparatus are being developed by which pressure may be given both during inspiration and expiration; when it is available this form of treatment may be periodically administered in a simple manner and in a less cumbersome apparatus than the hood, which is the only method now available that provides positive pressure in inspiration and in expiration. A simpler mask method of providing positive pressure in inspiration and expiration has recently been devised.\*

The pressure mask which we have previously described for provision of positive pressure in expiration has been modified to yield positive pressure in both inspiration and expiration. The injector Meter attached to the regulator, previously used to give varying concentrations of oxygen from 40 to 100 per cent, has been altered by the insertion in it of an additional venturi that results in a total flow

of air and oxygen of 44 liters a minute when 10 liters per minute of oxygen are used at a 40 per cent oxygen setting. When 15 liters per minute of oxygen are employed a combined oxygen-air flow of 45 liters per minute leaves the venturi to the mask at a 60 per cent oxygen setting (actual concentration being about 54 per cent). When the Meter is set at 50 per cent, a flow of 13 liters per minute will deliver a total flow of above 40 liters per minute, the actual concentration of inspired oxygen being 43 to 44 per cent. Expiration is delivered to a water bottle that may be set at 4 to 7 cm. of water. Due to the high total gas flow, the inspiratory positive pressure is 1 cm. (or less) lower than the expiratory positive pressure. Breathing under these circumstances is comfortable. The apparatus may therefore be used for the treatment of obstructive dyspnea in asthma, constricting lesions in the larynx and trachea, tracheobronchitis and pulmonary edema.

Inhalations of 75 to 80 per cent helium with 25 to 20 per cent oxygen may be given by the Meter mask at a flow of 6 to 7 liters per minute for periods of one half to one hour three to six times in the 24 hours. It has recently been found of special help to administer the helium oxygen mixture in conjunction with nebulization of broncho-dilator drugs.<sup>7</sup> The nebulizer is attached to the mask; a mixture of 0.5 cc. of 1:100 epinephrine (or 0.5 cc. 1:75 epinephrine in the Vaponefrin solution), 1.0 cc. neosynephrine and 1 cc. saline may be instilled in the nebulizer. In addition, isopropyl adrenalin, 0.5 to 1 cc. may be employed.<sup>8</sup> The helium-oxygen mixtures passes through the nebulizer, carrying the broncho-dilator aerosol into the mask. When nebulized solutions are employed with the mask it is desirable to place a piece of cotton in each nostril so that the aerosol may be inhaled through the mouth into the lungs; otherwise, the mucous membrane of the nose takes out about 60 per cent of the drug by deposition in regions of turbulence. The combination of inhalation of helium-oxygen mixtures with broncho-dilator substances is often of remarkable benefit when utilized in the morning on arising, at 3:00 to 5:00 P. M., at 8:00 to 9:00 P. M. or at midnight or thereafter whenever bronchial spasm occurs. The cumulative effect of periodic inhalations of helium with oxygen is itself beneficial and when combined with local broncho-dilator drugs often produces prompt relief of symptoms.

Nebulization of the broncho-dilator drugs mentioned above may be done by the hand bulb nebu-

\*Barach, A. L., Rumsey, C. C., Jr. and Soroka, M.: Continuous pressure breathing apparatus. To be published.

lizer, or more continuously by a stream of 4.5 to 5 liters per minute of oxygen with the nebulizer held in the open mouth. When a Y tube has been inserted in the rubber tubing, as is done in the administration of penicillin aerosol, the patient closes the open end of the Y tube at the start of inspiration and inhales the medication during inspiration only, allowing the nebulized solution to pass into the outside air during expiration.

Other drugs that may be employed when aminophyllin and adrenalin are not used during the 5 or 7 days period in which a remission is attempted include 2 to 4 cc. saturated potassium iodide, atropine gr. 1/150th to gr. 1/100th two to three times daily, and the anti-histamine drugs, especially pyribenzamine. The latter substance is at times of value in 100 mg. doses when 50 mg. has not been followed by noticeable benefit. Pyribenzamine may be given to adults conveniently in the following schedule: One 50 mg. tablet after breakfast and lunch, 200 mg. after dinner and before going to bed. When the patient is hospitalized or at rest at home with adequate care, 100 mg. should be tried after each meal and at bedtime. If a definite effect does not take place in three or four days with this dosage of pyribenzamine, the drug may be abandoned.

Antibiotic therapy has been recently tried in a considerable number of cases of so-called infectious bronchial asthma. Although much more time will be required to appraise with confidence the effect of penicillin treatment in patients with bronchial asthma, it can be said at this time that a certain number of cases are unmistakably benefited. Whether the proportion of significantly benefited cases will be somewhere between 20 and 25 per cent of cases of intrinsic asthma, or above or below this figure, is impossible to state at the present time.<sup>9</sup> In patients, however, who manifest a purulent quality to the sputum a trial of antibiotic therapy is warranted. Although a good deal of our experience and favorable results have been obtained with inhalation of penicillin aerosol, the fact that wheezing may follow inhalation of the mist in a fifth of the patients with bronchial asthma has recently inclined us to the view that penicillin is best given intramuscularly except when a highly resistant organism has been found on sputum culture.

The advantage of aerosol administration of penicillin in the presence of a resistant organism, such as *Staphylococcus aureus* which may become resist-

ant up to 5 units per cc., is that a concentration of 10 to 100 units of penicillin per cc. sputum may be applied by effective aerosol therapy. In many cases of asthma, we now use systemic administration of crystalline penicillin except in the presence of bronchiectasis in which aerosol is still administered as the preferred route. Injection of crystalline penicillin may be given in a 200,000 unit dose dissolved in 4 cc. saline at 6 hour intervals, or 400,000 units two or three times daily, depending on the blood level desired. A trial of two weeks' treatment of this kind will reveal whether or not reduction of bronchial infection is of value. In the presence of pneumococcus and hemolytic streptococcus organisms the indication for penicillin treatment is more definite; however, even in cases in which the predominating organism is *Streptococcus viridans* profoundly beneficial results have been obtained after adequate treatment with penicillin, either as an aerosol or by systemic administration.

In some cases in which there is evidence of purulent sinusitis the introduction of penicillin by the negative pressure technique which employs a venturi to produce an aerosol and also to develop a partial vacuum in the sinuses has been of marked value.<sup>11,12,13,14</sup> Penicillin aerosol may be produced by a stream of oxygen from a cylinder or by the rubber bulb which throws a mist into the nasal passages; a reversal of the venturi flow accomplishes the production of a negative pressure in the nasal passages and sinuses. Crystalline penicillin, 50,000 units in 1 cc., may be inhaled in this way three to four times daily for a period of two to three weeks, at times with removal of both the signs of sinus infection and the symptoms of bronchial asthma.

#### DISCUSSION OF METHODS OF SYSTEMIC AND AEROSOL ADMINISTRATION OF PENICILLIN\*

Systemic administration of penicillin appears to be most efficiently given by intramuscular injection of 25,000 units every three hours. This results in an effective blood level for most organisms; in some instances a higher dosage is indicated if the resistance of the organism to penicillin warrants it. Alternative dosages in our practice consist of 50,000 units at four hour intervals, 100,000 units every five

\*The observations in this discussion have been taken from studies in progress by Dr. Bettina Garthwaite, Dr. Hylan A. Bickerman and Mr. Irwin Wilson, the latter investigator being responsible for the determination of the particle size of aerosols produced by the various nebulizers.



hours, 200,000 units at intervals of six hours, 400,000 units at intervals of eight to twelve hours depending upon whether or not a nurse is available. We have employed crystalline penicillin for intramuscular injection and aerosol administration since it is less irritating in higher concentrations intramuscularly as well as by nebulization. The injection of penicillin in beeswax and oil has also been used but the frequency of the formation of painful lumps after five to six days has diminished our choice of this preparation. In some instances, when penicillin has been administered by aerosol or systemically during the day, 200,000 to 300,000 units of penicillin have been prescribed given in tablet form between 10:00 and 11:00 P. M.

When a patient with bronchopulmonary infection reveals an organism in sputum culture that is relatively resistant, such as up to 2 to 5 units of penicillin per cc., aerosol administration is indicated since relatively high concentrations of penicillin in the sputum have been obtained by this method, such as 100 units or more per cc. After intramuscular injection of penicillin the sputum concentration is generally zero, although occasionally traces of penicillin have been found in the expectoration after systemic use. If the bronchial tree is lined with a copious mucopurulent secretion, especially the purulent expectoration seen in cases of bronchiectasis, the inhalation of nebulized penicillin is at times of value when systemic employment of the drug is not followed by clinical evidence of improvement. In lung abscess the use of intramuscular injection of penicillin has been shown to be of sufficient value to result in clinical recovery in a number of patients. In other cases that have come under our observation and also that of Dr. Maurice S. Segal, inhalation of penicillin aerosol has resulted in clinical recovery when intramuscular injection of the drug has not been followed by apparent benefit.<sup>8,9,15</sup>

After a trial of various sulfonamide preparations for nebulization, we have selected tentatively a solution of 5 per cent sodium sulfadiazine and 5 per cent sodium sulfathiazole as the most effective and practical. Blood levels of 0.5 to 2 mg. per cent have been obtained after inhalation of 4 cc. of this nebulized solution with the oral rebreathing apparatus and 10 cc. with the mask method; the techniques will be discussed below.

In the use of streptomycin, blood levels of 0.5 to 16 mcg. per cc. have been demonstrated after inhalation of 0.3 to 1.0 gram of nebulized strepto-

mycin, a concentration of 1 gram in 10 cc. of water being generally employed. A total dosage during 14 hours of the day is generally between 2 and 3 grams of streptomycin. Relatively high concentrations of sulfadiazine and sulfathiazole and streptomycin have also been demonstrated in the sputum expectorated during a four hour period following their inhalation. The higher concentration is noted during the first two hours after the inhalation and a lower, but still high sputum concentration of these drugs is observed in the second two hour sputum sample. Our purpose in the administration of nebulized chemotherapeutic and antibiotic agents is the development of both a therapeutic blood level as well as a high local concentration of the drug.

The practical management of inhalation of nebulized penicillin has recently been simplified by the use of tablets of penicillin containing 50,000 units which are placed directly into the nebulizer and dissolved by addition of 0.5 cc. saline. A rinse of 0.5 cc. saline is inserted after nebulization if the hand bulb itself is used by the patient or by a rinse of 1 cc. saline if the penicillin solution is nebulized by oxygen or by an air pump. With a soluble tablet the patient is able to make the proper dilution of the drug without using a syringe and needle and, in addition, without the inevitable waste that attends the transfer of a concentrated penicillin solution from the glass ampoule to the nebulizer.\*

From the time of the extensive studies of Heubner, the effect of particle size on deposition and absorption of penicillin from the lungs has been studied by many investigators. Nebulized solutions which contain particles of relatively large size are deposited for the most part in the areas of turbulence in the nasal cavity or in the oral pharynx, few of them reaching the alveoli. Particles of extremely small size pass readily into the alveoli, but also are delivered in large part to the outside air during expiration, a variable quantity being deposited in the smaller bronchi and in the alveoli. It is naturally of considerable importance to determine the effective range of particle size in therapeutic aerosols for the treatment of conditions such as bronchial infection and pulmonary disease. In a current investigation, an experimental nebulizer has been made in which the particle size has a range of from 0.6 to 2.8

\*The soluble tablet for penicillin aerosol which we have employed in our studies has been supplied to us by the Premo Pharmaceutical Laboratories, Commercial Solvents Corp., and Bristol Laboratories.

microns in radius, the mass average radius being 1.3 microns. A comparison has been made to the Vaponefrin nebulizer in which the range is from 0.8 to 6.0 microns in radius with a mass average radius of 2.6 microns. The blood levels, sputum levels and urine levels of aerosols of the combined sodium sulfathiazine and sulfathiazole solution referred to above and of penicillin in concentrations of 50,000 units per cc. has shown no significant difference between these two nebulizers. The advantage of a fine particle size nebulizer is that irritation in the throat is perhaps less likely to take place when the majority of the particles are of an exceptionally small diameter since they are in more dilute concentration after lodging in the mucous membrane. The disadvantage of employing a fine particle size nebulizer is the increased length of time that is consumed by nebulization, from 30 to 50 per cent longer than that required by a nebulizer that produces particles of small and moderate size. Studies made with the DeVilbiss No. 40 nebulizer demonstrated a particle size that varied from 0.7 to 7.4 microns in radius with a mass average radius of 3.1 microns. The blood, sputum and urine levels in cases treated with comparable dosages of the sulfonamide and penicillin aerosols apparently show a slightly lower concentration of the drug in the majority of instances when the DeVilbiss No. 40 nebulizer is compared to either the "small particle size" (SPS) nebulizer or the nebulizer of the Vaponefrin type. However, when a nebulizer that produces particles of considerably larger size than any of the above is employed, such as the Parke-Davis nebulizer, the blood, sputum and urine levels are generally found to be considerably lower than those produced by other nebulizers tested.

The nebulizers considered satisfactory for aerosol therapy at this writing appear to be the Vaponefrin, SPS, and DeVilbiss No. 40; the most efficient in our experience is the Vaponefrin type.

Nebulization of a therapeutic solution during inspiration is economical since it avoids the loss otherwise incurred when the aerosol is produced during expiration also. The insertion of a Y tube in the rubber tubing between the nebulizer and the regulator allows the patient to manufacture aerosol during the inspiratory cycle by putting his thumb on the open end of the Y tube and allowing oxygen to escape during expiration. The nebulizer may be placed in the partly opened mouth or a rebreathing bag attached to a mouthpiece connected with the

nebulizer may be added in order to catch a part of the exhaled aerosol in the rebreathing bag and re-inhale it along with aerosol produced during the succeeding inspiration. In the majority of cases the blood levels are higher when the oral rebreathing method is employed, especially when the aerosol is humidified. As has been pointed out in previous reports, placing a glass of very hot water in the rebreathing bag and allowing the rebreathing bag to sit in a basin of very hot or boiling water permits the evolution of water vapor to join the stream of aerosol from the nebulizer, increasing the comfort of the inhalation and also the deposition of penicillin in the lung by manufacture of a more humidified particle. In addition, the concentration of the particle to which water vapor has been added is diminished and irritant effects of the aerosol appear to be less frequent. The oral inhalation of penicillin and streptomycin aerosols with the rebreathing bag humidified technique appears to be the most efficient method of administration, in terms of higher blood and sputum levels and, consequently, economy in the use of the drug.

For patients who are too ill to cooperate in the technique described above, a mask with partial rebreathing may be substituted. If the 5 per cent sodium sulfathiazole and 5 per cent sodium sulfadiazine solution is used, a flow of 10 liters per minute is employed in order to wash out exhaled carbon dioxide, since a mixture of carbon dioxide with the alkaline sulfonamide solution will otherwise lower the alkalinity and result in precipitation of the drug. Furthermore, the relative inexpensiveness of the sulfathiazole-sulfadiazine solution does not require the same precautions and economies that are indicated with the employment of either penicillin or streptomycin.

The use of an automatic demand valve attached to the regulator results in nebulization during inspiration only; by a slight lowering of pressure within the mask, oxygen flows through the nebulizer. In our clinic an apparatus was especially devised for this purpose;<sup>17</sup> later a simplified demand valve device was made by Mr. John H. Emerson.\* This may be used with a rebreathing bag, when the mask connection to the rebreathing bag is narrowed by a rubber cork with an internal three-eighths inch orifice. During inspiration a slight fall of pressure in the mask is produced which results in a flow

\*The Emerson Company, 22 Cottage Park Avenue, Cambridge, Mass.



of 10 liters per minute of oxygen through the nebulizer into the mask, at the same time the patient inhaling a small amount of aerosol of the previous expiration from the rebreathing bag. During expiration, the rise in pressure within the mask opens the valve so that oxygen is passed into the atmosphere. In operation of the demand valve nebulizer it is practical to allow a very slight nebulization of penicillin during the early part of expiration with the full delivery of oxygen through the nebulizer during inspiration. Markedly higher blood levels are obtained with the demand valve nebulizer than when a mask is used with continuous delivery of chemotherapeutic or antibiotic drugs.

An important factor in the efficiency of mask administration of aerosol is prevention of nasal breathing since it results in a far lower deposition of the drug in the bronchi and lungs. When nebulized penicillin, streptomycin or the sulfonamides are inhaled with the mask, with nasal breathing permitted, the blood levels are one half to one-third as high as when the patient breathes entirely through the mouth, accomplished by placing a cotton sponge into each nostril during the period of nebulization, in that way completely preventing their deposition in areas of turbulence in the nasal and nasopharyngeal passageway.

A closed head tent has been employed for simultaneous administration of oxygen and penicillin and other therapeutic aerosols in patients who are seriously ill and in children in whom cooperation with other techniques is difficult. An oxygen tent for inhalation of nebulized penicillin was suggested by Knott and Southwell.<sup>18</sup> When the head tent is used the nebulizer is placed within the tent and the aerosol is directed toward the front of the tent or toward the mouth of the patient. Considerably higher dosage of the drug is required to maintain comparable blood and sputum levels by this technique. From 500,000 to 1,000,000 units of nebulized penicillin per day have been employed in the head tent in adults who have had severe bronchiectasis, pneumonitis, or lung abscess, whereas dosages from 250,000 to 500,000 units are generally adequate to cope with the condition with the oral rebreathing apparatus. When the head tent is employed a lower concentration of penicillin is utilized so that the administration may be more nearly continuous or semi-continuous. Thus, 5,000 to 10,000 units per cc. may be delivered by a flow of 8 liters per minute of oxygen through the nebulizer, a dose of 100,000

units being given at two hour intervals for five to ten times daily, depending upon the severity of the infection. In order to allow for elimination of carbon dioxide in adults, the posterior two inches of the covering of the head tent is folded forward so that air is admitted at the back which passes through the ice compartment to the front part of the tent. This precaution is not necessary for children since the small amount of carbon dioxide eliminated allows the top covering to be completely closed.

In some cases an automobile foot pump, in which the lubricating oil has either been removed or eliminated by a filter, has been used as the source of nebulizing power by patients in whom the expense of oxygen equipment is a formidable item.<sup>14</sup> With the development of the soluble concentrated crystalline penicillin tablet, which is inserted directly into the nebulizer, nebulization of 50,000 units in 0.5 cc. with the hand bulb has been employed by some patients without undue fatigue. This requires compression of the hand bulb two or three times during an inspiration until one half cc. of the saline solution containing 50,000 units has been nebulized, and a succeeding rinse of either 0.25 or 0.5 cc. saline is also nebulized. If solutions are made up of 50,000 units per cc., nebulization of 1 cc. with a following rinse of 0.5 cc. necessitates so much muscular effort with hand bulb nebulization as to result in excessive fatigue. An alternative method of nebulization of penicillin is to use a dosage of 25,000 units at two hour intervals, with 0.25 or 0.5 cc. of diluent (conveniently measured from a dropper). Our preference is the 50,000 unit dosage repeated five times during the day, either with or without a night injection or oral administration of 200,000 units of penicillin.

In the recent simplification of the sinus penicillin aerosol apparatus, the valve has been dispensed with and the nebulizer is connected directly with the venturi.<sup>13</sup> A tablet of penicillin is placed in the nebulizer, dissolved with 0.5 cc. saline or boiled water, and the patient may nebulize this either with a flow of 6 liters per minute of oxygen, producing an aerosol when the open end of the venturi is closed and negative pressure in the nasal passages by swallowing when the venturi is open. A similar result may be obtained in patients who use the hand bulb, compression of the bulb being used both for delivery of the aerosol and for the production of negative pressure. This simplified method of withdrawing air from the sinuses and replacing it with a mist

of penicillin or streptomycin or sulfonamide aerosol would appear to be of therapeutic and practical value for a considerable number of patients with both acute and chronic sinusitis. For those who are able and willing to use the hand bulb, the expense of this form of therapy is decreased by the omission of oxygen and a cylinder regulator.

Although concentrations of 50,000 to 100,000 units may be used in nasal inhalation of nebulized penicillin, it should be borne in mind that these concentrations are excessive for introduction of penicillin with an atomizer. In the latter use of the drug, concentrations of 1,000 to 2,000 units of penicillin at one or two hour intervals may be employed for nasopharyngeal infection.

The efficiency of aerosol penicillin in the production of an effective blood level is far greater than that accomplished by oral ingestion of the drug. In our studies only 10 per cent of adults showed a demonstrable blood level after ingestion of 50,000 units of penicillin by mouth, whereas patients who inhale 50,000 units of nebulized penicillin will show from 0.1 to 0.2 units of penicillin per cc. serum during a period from the end of administration for two hours thereafter. Furthermore, a minimal level may be observed for the following one half hour period. It is safe to say that an effective blood level is maintained for a period of at least three hours following the inhalation of 50,000 units of crystalline penicillin in the majority of patients. This does not take place after administration of a comparable amount of the drug by mouth; in fact, the blood levels after ingestion of 100,000 units of penicillin by mouth are approximately one half those obtained by inhalation of 50,000 units of nebulized penicillin. The procedure may, therefore, be used for systemic administration of penicillin in patients in whom intra muscular injection of the drug is not feasible. The only complication that has been noted in aerosol penicillin therapy has been the development of a reddened tongue and throat, occasionally a black looking tongue, in a small percentage of cases. This is less commonly observed when crystalline penicillin is employed, but in susceptible patients it has been noted; in these cases the use of penicillin in this form has to be temporarily stopped. Humidification of the aerosol as described above makes the likelihood of irritant effects less; reducing the concentration of the solution to 10,000 to 20,000 units per cc. is also helpful.

In a number of patients who suffer from broncho-

spasm, either those who have bronchial asthma or pulmonary emphysema, the inhalation of nebulized penicillin may be followed by a non-allergic irritant effect that results in wheezing. When this takes place it is better to abandon aerosol administration and to use intramuscular injection of the drug. In other cases the procedure has been continued with a previous inhalation of a broncho-dilator drug, such as 1:100 epinephrine or 1:75 epinephrine (Vaponefrin), 1 per cent neosynephrine. It must be recognized that inhalation of the above broncho-dilator drugs result in vasoconstriction and in a consequent lowering of the blood level of penicillin. Although the penicillin may be subsequently absorbed as the vasoconstriction decreases, the drug is lost if the patient has considerable cough since it is removed with the subsequent expectoration of sputum. The recent introduction of isopropyl adrenalin may be of value in these cases since vaso-dilatation is apparently produced at the same time that bronchial dilatation takes place. The combination, therefore, of a previous or simultaneous inhalation of penicillin aerosol dissolved in a dilute solution of isopropyl adrenalin may be helpful in patients with bronchospasm in whom the effect of a mist of any drug is that of stimulating bronchial spasm. In many patients with asthma the sputum is not so copious or purulent as to require aerosol rather than systemic administration. In cases, however, in which resistant organisms have been found, the use of nebulized penicillin may be necessary in order to develop a high local concentration of the drug on the broncho-pulmonary surface.

In a previous publication\* an appraisal of the clinical results of penicillin therapy and physiologic therapy was described as follows:

"Of 91 courses of penicillin therapy in 60 cases of severe bronchial asthma, clinical improvement was marked in 16, moderate in 19, slight in 36 and absent in 20. The duration of improvement in 35 patients who were moderately or markedly benefited was over two months in 21 and less than two months in 14. In 60 cases who manifested marked or moderate improvement as a result of physiologic therapy, improvement was sustained over two months in 39 and less than two months in 21.

"More sustained improvement after antibiotic penicillin therapy in the treatment of bronchial and

\*Barach, A. L. and Garthwaite, B.: Physiologic and Antibiotic Therapy of Intractable Bronchial Asthma. *Ann. Allergy*. To be published.



sinus infection appears to take place in cases in which hyposensitization therapy with catarrhal vaccine and dust is instituted directly after treatment and continued for an indefinite period thereafter.

“Further studies are required to determine the role of gram negative organisms that appear subsequent to penicillin therapy in cases of broncho-pulmonary and sinus infections. Current investigations of streptomycin and sulfathiazole as aerosols point to the possibility that cases of mixed infection unresponsive to penicillin therapy may be benefited by antibiotic treatment effective against both gram positive and gram negative bacteria.”

Of the non-specific measures that have been employed to terminate a state of intractable asthma two developments in technique have been found of value in our clinic.

Fever therapy produced by artificial means as well as that which takes place spontaneously in the course of infection has long been known to result

TRIPLE TYPHOID VACCINE-GLUCOSE INFUSION UNIT

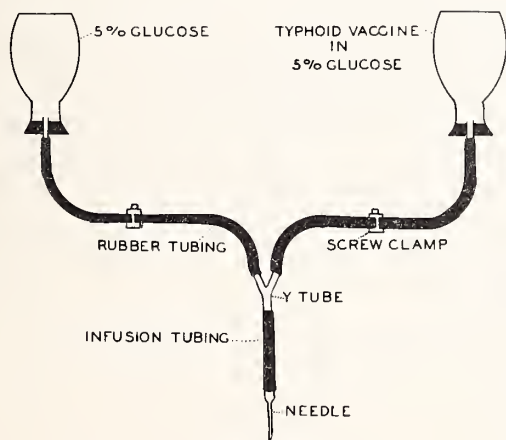


FIGURE 1

Artificial fever therapy with typhoid vaccine and two flask technique

in a remission in the symptoms of severe asthma in a number of cases. The hyperthermia chamber has been employed in a number of our patients, but more recently we have modified slightly the technique of Solomon and Sonkin<sup>14</sup> in which an infusion of typhoid vaccine in glucose is employed. In the accompanying illustration (Figure 1) it is seen that two flasks are used, one of which contains 0.3 cc. triple typhoid vaccine in 5 per cent glucose and the other 5 per cent glucose itself. A slow infusion of 40 to 60 drops per minute of typhoid vaccine in glucose is begun, the temperature is taken

at 15 minute intervals until a fever of 103° F. is obtained. At this point the solution from the typhoid vaccine-glucose flask is clamped off and plain 5 per cent glucose is allowed to run into the vein until the temperature drops below 102° F. The nurse then removes the clamp from the typhoid vaccine flask and stops the flow of plain 5 per cent glucose. A fever of 104° F. or at times 105° F. maintained for three to five hours and repeated in two or three days is often followed by a termination of the asthmatic state.

Both bronchoscopy and ether have been employed in the treatment of severe asthma with beneficial results. Our procedure at Presbyterian Hospital recently has been to combine these methods. The patient is brought under deep surgical ether anesthesia which is maintained for a period before, during and after the bronchoscopy so as to consume twenty to thirty minutes. The bronchoscopic suction is thoroughly carried out, 1:1000 adrenalin is then instilled through the bronchoscope to both lower lobes and suction is again performed until all secretions have been removed. In this way, many patients, especially those in whom the peristaltic action of the bronchi and ciliary activity are impaired, are remarkably benefited. In fact, this procedure is at times a life saving measure in older people when all other attempts at therapy have failed. Bronchoscopic suction under ether is to be preferred in our experience to local anesthesia with cocaine, since occasionally patients are found who are sensitive to cocaine.

Filtered air is of special value in cases that are sensitive to airborne allergens, such as pollen. In the use of filtered air continuous operation of the motor blower unit should be maintained.

SUMMARY

A consideration of physiologic and antibiotic therapy in intractable asthma has included a review of the pathologic physiology of obstructive dyspnea and a presentation of a bronchial relaxation program. The regimen described includes the temporary curtailment of epinephrine and, in patients who are refractory to aminophyllin, of the latter drug as well, the use of demerol and other drugs, oxygen, helium-oxygen mixtures, pressure breathing and the aerosols of epinephrine, neosynephrine and isopropyl adrenalin. The value of intermittent in-

\*The Airgard filter is a practical and simple apparatus for this purpose.

halation of helium-oxygen mixtures in conjunction with simultaneous nebulization of broncho-dilator substances has been indicated. The value of antibiotic therapy in a limited number of cases in the treatment of bronchial and sinus infection has been reported. Recent methods in the systemic and aerosol administration of penicillin are presented.

Recent developments in the technique of fever therapy and in bronchoscopic suction in combination with ether anesthesia are described.

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## IF CHILD GUIDANCE CLINICS — WHY NOT PARENTORIUMS?

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LAST YEAR, 108,000 youngsters under 21 were arrested in this country for juvenile crimes. At least as many young sons and daughters of our land were taken to child guidance clinics and counsellors by mothers and fathers desperate for help. Additional thousands of children presented serious behavior problems to their long-suffering parents and teachers.

This shocking record is nothing new on the national horizon. Parents, teachers, psychiatrists, sociologists, and the clergy are painfully familiar with juvenile delinquency and behavior problems; we have been theorizing for years about child training, home environment, raising good citizens, and so on . . . but like Jack's beanstalk, the problem has been growing bigger and bigger in spite of our good intentions.

Let's look the matter squarely in the face. What are the factors responsible for juvenile delinquency and behavior problems? And more important, what can be done about them?

To find the answer to the first question, we need not search far. It is clearly shown in police court proceedings and psychiatrists' case books that most behavior problems in children stem directly from faulty home training. Ample evidence proves that the most important causative factor in juvenile delinquency is *parental* delinquency!

Lately, we have been hearing a great deal about 'delinquent parents.' J. Edgar Hoover said last week that in his twenty-three years as director of the F.B.I., he has found that juvenile delinquents are the products of neglect and improper training, and the actions of the majority of them are directly related to the conduct of their parents.

Further, on the basis of information compiled in

a recent survey of 30,000 convicts who have gone through the psychiatric clinic at San Quentin Prison during the past fifteen years, it has been announced that the most important contributing factor to the flood of criminals today is the failure of parents to teach individual social responsibility.

How did the parents fail? By lack of supervision and neglect of their children? By the bad example of dishonesty in the home setting? By being satisfied with slum living conditions?

Obviously those are glaring flaws in home life. No one denies that such conditions are breeders of discontent, maladjustment, delinquency, and crime, and as such must be eliminated.

However, in present-day parenthood, there are trends which are not nearly as obvious as parental neglect or slum living conditions, but are even more dangerous by virtue of their subtlety.

One of these trends is what I call "the glorification of childhood and immaturity." In other words, too many parents these days don't want their children to grow up! Expressions such as "She's only a child!" and "Oh, but he's so young, give him time," are heard all too commonly in defense of a son or daughter, even after that son or daughter has reached voting age. It would seem that the modern individual almost needs the badge of grey hair, or no hair at all, before he is expected to think and act maturely.

Now, how can a person think and act maturely if he has never practiced at it? In my profession, I have seen too many adult adolescent personalities who, faced with a difficult decision or a misfortune, are unable to rise to the occasion. They become bewildered and confused, and some retreat into alcoholism or mental illness. They are sort of engulfed in a wave of reality; but basically most of them are probably neither different from nor weaker than the rest of us. They just have never learned to swim.

*Presented at the Rhode Island Congress of Parents and Teachers, Narragansett Hotel, Providence, Rhode Island, Wednesday, April 30, 1947*

Closely related to the glorification of immaturity is the human tendency on the part of parents to protect their children from all sacrifice and unpleasantness—to keep their childhood a shining dream free from heartache and disappointment. Seriously, can real life be anything short of a nightmare to a child who has experienced only a dream filled with sugar and spice and *everything* nice?

Children instinctively covet the estate of adulthood. They covet the visible trademarks—long trousers, a hat like Dad's, high heels and lipstick—and they are equally responsive to learning self-restraint and individual fortitude, if we give them a chance. Let's make sure when Daddy's little man sets forth in his first pair of long trousers that he knows enough about life to be allowed outside his play-pen.

Training for life is no different from other training. If we were teaching a boy to be a farmer, we would acquaint him with the hard labor of farming and the dangers of crop failure as well as with the joy of watching things grow and the satisfaction of good harvests. We would want him to be a good farmer in all kinds of weather.

Training for life is the same. To be able to survive the storms in this world of sin and suffering, an individual must be prepared to meet the struggles as well as the windfalls. It often has been said that military service "made a man" out of an individual. If parents were on the job, we wouldn't need a war to help our children grow up.

The discipline of social responsibility should be taught in the early years. Learning to live will be a natural, evolutionary process if the child is taught early, in his daily, uncomplicated relationships with other children and adults, to connect a socially affirmative act with social reward, and an anti-social act with social punishment.

In no way am I advocating "You mind because I say so." Remember that the most frequently used word in a child's vocabulary is "Why?" "Why mustn't I hit little sister?" "Why mustn't I take candy in the store?" "Why must I pick up my blocks?" "Why does it rain?" "Why" is the golden key of opportunity to tell them why in terms they can understand. The dictatorial "Do this. Do that." technique may bring model obedience at the moment, but Papa will not always be there to tell the child what to do and when.

Similarly fallacious is the *lollipop technique*: "Don't slap little sister today, and I'll give you a

lollipop." That tactic is never effective longer than the lollipop lasts, and further, Papa will not always be there to hand out the lollipops!

Parents are obligated to prepare their children for life by developing in them a mature outlook, by teaching them to do things because they are right and helping them learn to understand what is right according to the rules of society as they obtain.

Only by such an understanding will they be able to participate as adults in making those rules, and only by such an understanding will they be able to cope with them.

There is little in life more inflexible than social rules, and their inflexibility places the modern school of indiscriminate "self-expression" in a ridiculous position. Self-expression is a fine outlet for the emotions and should be encouraged for personality development, but society will not tolerate conduct that is not within the established social pattern, and wise parents guide their children's activities and interests accordingly.

The mother who allows little Johnny to use his little axe on the piano leg because he is "expressing" himself should not be too surprised if little Johnny is still "expressing" himself at the age of twenty-one by using the axe on someone's head! Usually a child who is not trained to conduct himself in a socially acceptable manner is destined to become a very unhappy, or even a sick, individual, because on him or her society will dole out its punishment, all the way from neighborhood ostracism to a prison sentence.

Another dangerous trend is the increasing "over-aspiration" on the part of parents. It is natural for parents to be proud of their children's accomplishments, but to demand too much is to invite trouble. A grave example is the tendency to aspire to a college education for every child, whether or not he has an academic mind. I have seen innumerable instances where the family scrimped and saved to send little Willie to college. They looked to him to "be something," the consummation of all their efforts, but in more than one case, he couldn't take it and finally "blew a fuse." The tragedy in that real life drama is that by following another vocation for which he was better suited intellectually and emotionally, little Willie would probably have grown up to be a very happy, useful citizen.

Parents have an unparalleled opportunity to develop in their children the ability to enjoy life to the fullest, making the most of their attributes and



accepting their limitations in a successful adjustment to the social pattern.

In this regard, I like to think of each individual as sitting on a four-legged stool. One leg is a vocation, not necessarily an activity for monetary return, but some activity which fulfills the human need to be of some use to someone. Without a vocation, a man or woman has no place in society.

Then, inasmuch as man has a need for play but few of us can do for a living that at which we like to play, the second leg of the stool is an *avocation* or *hobby*. Since man is a social animal, the third leg is the *social* and *recreational* aspect of life, and the fourth leg is the *physical* aspect—the body is the vehicle of the mind. These four phases of living, well developed and constantly nurtured, satisfy man's basic psychological needs.

Any individual who is sitting on a stool with four well developed legs of proportionate length is sitting pretty, and for some individuals, two or three legs may be satisfactory; but there are very few persons who do not totter if they try to balance on one leg. Develop that stool for your child to sit in throughout life, and there is not a chance of his breaking down psychologically.

Another trend I have observed in the American population, and even in the world population, is an obsession "to get something out of everything."

Youngsters are launched in grammar school with the admonition, "Now, I hope you're going to *get* something out of this," and the same feeling prevails in the high school period, in college, and even in the adult working world. With that idea instilled in their minds, our young people are finding it difficult to grow up without a serious case of the "gimmie-gimmies."

There are many good things in our society for which we should be thankful, and none of them ever resulted from the "gimmie-gimmie" attitude. The good things, in every instance, stem from what we might call the "give-give" attitude, or the desire on the part of the individual to give in the best interest of the group. We might better alter our admonition to youth by saying, "I hope you're going to get something out of this so you may be prepared to carry out your responsibilities in society."

The most dangerous tendency of all is parents' "over-anxiety" about their children—and here I fear psychiatrists unwittingly may have been somewhat

responsible for the situation. Such warnings as "If he moves his hand one way, make a note of it; it has some significance," or "If she has a dream, scratch it down; it must mean something," have made parents so anxious that they are reading psychiatric implications into the child's every thought and action. Some parents are so anxious they are on the verge of needing psychiatric advice themselves!

There is no more positive way of imparting anxiety than to be anxious, so instead of looking for trouble, and perhaps thereby creating it, we might better temper wisdom with poise, leaving the children alone with their fortune in the lap of chance.

Also, there is the matter of divorce, which I broach with great hesitancy, but as I see it, we in this country need to be reminded that parents have no rights that transcend the rights of their children. The court may decide a fifty-fifty financial settlement for a mother and father who have come to the parting of the ways. What about the children? Are they divided fifty-fifty, too? Do we have the right or the ability to weigh the respective goodness and badness in each parent, and to dole out the children accordingly? Believe me, if a child has any tendency toward a split personality, such a court decision will put the finishing touches on the job. We might better be a Solomon and threaten to cut the youngsters in half!

Perhaps if we had the wisdom of Solomon we would be blessed with the genius to correct these factors leading to childhood delinquency and behavior problems, but restricted as we are to the commonplace vision of ordinary mortals, what can we do?

Two things are already being done. One is the passage of laws to hold parents legally responsible for the actions and welfare of their children. The other is the establishment of child guidance clinics.

A few months ago, it was front page news, and a turning point in the attack on childhood problems, when a young mother was arrested with her fourteen-year-old son for his sniper-shooting of three persons in New York City. Her arrest was the first in a campaign headed by New York City Police Commissioner Arthur W. Wallander, who had previously served notice that parents who contributed to their children's delinquency by willful failure to supervise and control them would be prosecuted. Found guilty, she was sentenced to one year in the Woman's House of Detention.

Other states are following suit. In Connecticut, for instance, more and more use is being made of a state statute that prohibits endangering the health, safety, or morals of children under sixteen, and carries a maximum penalty of \$500 or ten years in jail.

Then, too, child guidance clinics, which have undergone an astonishing growth during the past twenty-five years, are performing an invaluable service in helping youngsters who need training supplementary to that of their parents.

We have child guidance clinics, in which efforts to correct faulty childhood behavior patterns have demonstrated the wisdom of parent guidance. Why not have *parentoriums*, or parent guidance centers, where parents could receive instruction in child training techniques?

These training centers might be of two types—one for prolonged, intensive training, and another on a day-student basis.

In many instances, a child's difficulty is so profound that prompt and radical action is necessary. Yet, parents are often too slow in learning to correct their methods of teaching social responsibility, or they find it impossible to learn while they remain in the midst of the family circle.

In those cases, they might leave home for a period of residential training in a parentorium, thus giving themselves "the power to see themselves as others see them," and also allowing the home situation to settle down.

Of course, the vast majority of parents needing help undoubtedly could be trained in parentoriums on a day-school basis; and naturally, all mothers and fathers *do not need* help.

However, many otherwise successful parents might attend some of the classes to improve their techniques; for instance, a parent might enroll in the class, "Over-Anxiety About Your Children," in order to dispel his apprehension and learn how to handle the situations that are causing him anxiety. Others might attend classes called "Current Glorification of Immaturity," "Dangers in Over-Protection," "The Fallacy of the 'Do this. Do that.' Technique." "The Archaic Lollipop Technique," "The

Right Kind of Self-Expression," or "The Gimmie Gimmies Versus the Givie-Givies."

Parentoriums might best be a part of existing educational systems, but the question of who should establish them is less important than that they are established. Under no circumstances would I look upon them as a purely medical function or as necessarily being related to sickness of any kind. My "parentoriums" would be concerned entirely with the hardheaded educational task of teaching parents to teach their children the discipline of self-restraint and social responsibility.

One last comment on the word *discipline*: Certain schools of thought have taught selfishness and lack of self-control to the extent of rejecting all that is represented by discipline. Some exponents even go to the extent of not using the word, under the erroneous assumption that the child and the man are reasoning animals at all times, which they are not and undoubtedly will not be for a great many generations to come, if ever.

I say that self-restraint and social responsibility cannot be taught without discipline, tempered with understanding and love and guided by individual differences, of course; and parents are in the best possible position to do the teaching. The home without discipline is like a state without laws.

Finally, individual differences must be the keynote of any child training program. Every child is an individual different from every other, even those within the same family, and we cannot lay down a standard pattern. The most we can do is to formulate basic principles which may be adapted to each child.

I fear that my remarks may paint me a harsh disciplinarian devoid of all affection for the young, but the fact is that because I do have affection for the young, I am differentiating an unfettered childhood and its ultimate distress from a childhood which will bode life-long happiness. My feelings on the subject are product of thirty-nine years in the field of psychiatry, during which time I have made nearly all the mistakes there were to be made, and it is with a sense of appreciation for those mistakes that I commend these ideas and myself to your tender mercies.



## MODERN INFLUENCES IN MEDICAL PRACTICE: UNDERGRADUATE MEDICAL EDUCATION

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The Author. *Associate Dean, Long Island College of Medicine*

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**B**ETWEEN undergraduate medical education and medical practice there exists a relationship that has several reciprocal aspects. To medical educators are assigned the responsibility for the selection of likely candidates for medical practice as well as the administration of a curriculum which best provides the basic professional training needed for general practice or preparation in a specialty. On the other hand, the form and content of this curriculum should be conditioned by the main trends in medical practice.

Medical students are the practitioners of the future. Consequently, it is the concern of medical schools that their educational services be designed not only to meet what might appear to be present requirements but to anticipate, if possible, those of the near future.

At this forum, it is my purpose to consider some phases of the quantitative adequacy of modern medical education in meeting needs of medical practice. Reference to its qualitative adequacy must of necessity be brief and frequently only implied.

In measuring quantitative adequacy one must begin by examining the source of the future purveyors of medical services. In the prewar years, an average of 12,000 candidates applied for admission to approved American medical colleges each year. Approximately 5,700 were selected and 4,900 were graduated. From so large a source of selection one might assume that virtually all places in freshman classes were filled by completely satisfactory candidates. Unfortunately, this has not been the case. The growth of the fundamental sciences and the

rise in social prestige of other professions have made it difficult for medicine to compete as well as it did in the past for the brightest young men in our colleges. One might ask, is there something wrong with the present form of medical practice as now organized that is unattractive to some potential candidates for medicine? Are there limitations to opportunities in practice, in research and clinical investigation? Are science courses in American colleges and high schools so badly presented that prospective students lose interest?

Suggestions that may increase the number of adequate candidates for medicine are these: The first is the award of scholarships and loans by local, state, and federal government to deserving young men and women unable to afford the cost of a medical education. Residents of rural areas should be favored in the award of such grants. The rising cost of tuition and the longer period of house officer training are combining to make the trail our future associates must follow more hazardous from the financial point of view. Medicine, alone, among the professions, deprives a man of a livelihood for six to ten years.

A second suggestion is the recommendation that positive encouragement be given prospective women applicants. Women have been discouraged from starting premedical studies because of the relatively small number that have gained admission to American medical colleges. Until recently women represented only about 5 per cent of the total enrollment of medical students. During the latter part of the war many more women were accepted and, in the present first year class, women comprise 12 per cent of the total. There is little doubt that an untouched reservoir of good doctors can be found among women students.

*Reprinted from the West Virginia Medical Journal, June, 1947*

*Read at the 20th Annual Meeting of the National Conference on Medical Service, Chicago, February 9, 1947*

Before discussing the question, "Do We Need More Doctors?", it is well not only to emphasize the relative paucity of fully adequate first year applicants but also to call attention to the obvious corollary that medical care in this country hardly will be benefited by graduating more doctors unless there is assurance that the quality of the product not only can be maintained but improved.

In the United States there are sixty-nine approved medical schools which grant the M.D. degree. Their graduates totalled about 5,700 in wartime, but this number now will fall to about 5,000 each year. (The higher complement during the war came as the result of a 10 per cent increase in the admission rate, requested by the military services.) In the five year period before the war, an average annual increment of 818 graduates of foreign medical schools was licensed. This number already has sharply declined (209 in 1946) but may increase again in the near future. If we assume that 8 per cent of our annual output of doctors will come from foreign unapproved medical and osteopathic schools, as at present, it can be predicted that each year approximately 5,400 new doctors will replace the 3,600 who die, the latter figure being an average for the last five years. This means an annual net gain of at least 1,800 physicians which doubtless will continue for some time.

In the United States there are said to be 195,000 physicians supplying the needs of 140,000,000 people—or one physician for every 718 persons. This crude method of estimation ignores the number of physicians who are retired and those partially inactive by reason of age or illness. It is an unsatisfactory yardstick to measure the quantitative adequacy of national health care when there is little uniformity in the distribution of doctors, what with their concentration in the city and the smallness of their numbers in suburban and rural areas.

Many physicians are engaged in activities that do not involve them as direct dispensers of medical care to the general public; still others are in military service, public health service, and the Veterans Administration. Medical education, industry, and insurance claim the interest of not a few. The participation of so many physicians in these fields significantly reduces the number of those available to care for civilian practice. In these several directions the annual net increment of 1,800 physicians is partially expended. Despite these deviations it

seems undesirable to alter the present physician-population ratio until efforts to achieve a better distribution of doctors and their services are successful.

It is extremely difficult to estimate the number of physicians needed to provide complete medical services for a given community. Yet on such data will depend our ability to reach an approximation of the number of physicians to be trained annually.

Among other factors, consideration must be given the following: Will medical practice continue predominantly in its present form—each physician functioning more or less independently with his personal private practice—or will group medicine largely supercede the traditional method?

Do not the implications of group practice suggest that by reason of cooperative efforts there is economy in the use of medical personnel? Physicians united in a group may be able to care for a larger number of patients than they could if not so organized. If American medical practice were to be modified largely as group practice, this might significantly alter the present number of physicians needed per unit of population. But, there is still another factor that would affect such an estimate. The nature and organization of group practice are such as to favor the provision of preventive as well as curative services. If, in group practice arrangements, preventive medical services are offered in their fullest sense, a larger number of physicians might be required for the same population unit. This need would be reflected in the national picture and it might be necessary to increase the enrollment of medical students.

The inclusion of a broad program of preventive services probably will add to the cost of medical care, already great. Over a period of years this larger investment will reap the dividends of better health and in the long run may prove less expensive.

The ability of the American people to purchase medical care is pertinent to this discussion. As medicine has become more effective, its cost has risen. We may expect that both will continue in upward trend. Because of the unpredictable occurrence of illness, a large segment of the population is unable to meet the costs of medical treatment. Through enrollment in one of the many voluntary prepayment plans that are fast developing there is expectation that this situation will be eased in part. Approximately five million subscribers have been en-



rolled in plans sponsored by state and local medical societies. Sixteen million are Blue Cross subscribers. As experience accumulates it is hoped that a much more complete form of coverage will be made available.

It is quite evident that the parallel developments of prepayment insurance and group practice go hand in hand. Prepayment insurance is more easily organized and distributed through an arrangement with a group.

There is a strong trend toward group practice in this country. In a survey conducted among physicians in military service, Colonel Lueth reported that somewhat more than half expressed a preference for group practice. A large number of groups now are in the process of formation.

Unfortunately, there is not as yet sufficient experience in organized group practice to answer the following questions: How many physicians are needed to care for a given unit of population of a size sufficient to support the group on a prepayment basis? How many family doctors and how many specialists? What would be their relation to one another? What would be the scope of the family doctor's interests and responsibilities? What would it cost?

An experiment in the field of group practice and comprehensive prepaid medical care is the Health Insurance Plan of Greater New York which is about to start functioning. This organization will contract with groups of physicians who agree to accept the care of subscribers and their families who have voluntarily enrolled as employed groups. Complete care will be given with the exception of some forms of chronic illness and dental service. The annual fee for Blue Cross hospitalization and the physician's services is expected to be \$41 per employee, \$82 for one dependent and \$120 for the family. Half of this fee will be paid by the employer and the other half deducted from the subscriber's pay check. This will mean \$60 for the employee's entire family for virtually complete coverage. On the basis of the experience of others, one group that expects to operate under the Plan assumes that to care for 40,000 patients, fifty full time doctors or their equivalent in part time service will be needed. It is not necessary that any of the doctors be on a full time basis. Eighteen family physicians, four internists, two pediatricians, five obstetrician-gynecologists, five general surgeons, ten surgical

specialists, one radiologist, one pathologist, one psychiatrist and so on might be an appropriate set-up. These figures are mentioned because, interestingly, they assume a ratio of one doctor for every eight hundred patients and indicate some idea of the different types of physicians required.

Remuneration for the doctors will range from \$5,000 to \$15,000 and will average \$10,000.

I believe it is the responsibility of medical schools to foster experiments that may offer methods of enhancing the effectiveness of medical practice as well as those which would insure better distribution of medical and health services. Group practice, voluntary prepayment insurance plans, and complete medical coverage are the experiments of the moment that require testing. The investigative talents of a medical school faculty preeminently qualify them for a study that requires the same objective measurement as do laboratory experiments. Medical students should be taught not only the scientific aspects of medicine, but should have first-hand experience with all distributive forms of medical care and with group practice in particular.

A medical school has the facilities to provide the undergraduate with an opportunity to observe critically the operation of a prepaid group clinic by family physicians and specialists providing complete and continuous care in the hospital and home to the patient and his family. Such care should include not only curative treatment but a positive program for maintenance of health.

Compare this suggestion with the current system. At the present time virtually all clinical training is centered in and limited to the wards of teaching hospitals. Many students will spend an additional four years or more on the same or similar wards as house officers. How narrow may become their point of view by this continuous and restricted exposure to one side of medicine—that of serious episodic illness? How else can we implant the seed of a broad interest in family health except by providing exposure to the home environment and to doctors engaged in such practice? This exposure should continue through house officer training as well. With such a foundation we might hope that specialists of the future will retain these interests and acquire some points of view of the general doctor.

There is justified concern that the general or family doctor will be lost in the rush of specialization. The family doctor is so uncertain of his future

that few medical students now aspire to enter general practice. The proposed experiment enhances the importance and place of the family doctor in the group and allows for determination and definition of the proper use of his skills.

In conclusion, may I suggest that medical educators defer consideration of increasing the annual number of graduates until more equitable distribution of those now available is accomplished. It is essential that there be experiments in group practice of all kinds. A variety of voluntary prepayment insurance plans offering complete coverage is needed. Medical schools of their very nature are

well qualified to foster and take part in such experiments. May I call your attention to the widening concept of the role of medical schools—from a place where undergraduates heard lectures on medical topics to a share in the leadership of raising standards of medical care? This has ranged from demonstrations in rural health such as the Bingham Associates Plan in Maine to assistance to the Medical Department of the Veterans Administration on a national scale.

How will medical educators help meet this greatest challenge—high quality comprehensive medical care at a rate that the American people can afford?

## STATE PROGRAM FOR CHRONICALLY SICK

A. N. CREADICK, M.D., *New Haven*

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The Author, *Chairman, Commission on Chronically Ill, Aged and Infirm*

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CONSIDERABLE SUMS of taxpayers money are being expended annually for the welfare of the people of Connecticut. Each biennium there are groups of interested laymen who advance new claims for special sufferers and appeal to the General Assembly. The recent session was particularly troubled because war restrictions had limited the possibilities of structural maintenance for some years and it was apparent that drastic measures were required at this time to bring some institutions into repair. At the same time costs had mounted for personnel services, food and fuel. The sums required proved so heavy that few new ventures or new buildings could be authorized. Indeed, it was impossible to maintain satisfactory services without resort to new forms of taxation. Such measures are always unpopular; every one is eager to support suitable services for the people although no one seemed cheerful about paying for them.

In the face of these circumstances the Commission on the Care and Treatment of the Chronically Ill

proposed that their problems be considered and suggested that this "care and treatment" could be conducted in "already existing" plants by additions and some alterations in present use. Furthermore, the Commission maintained that at present too much care now prescribed and paid for by the town, state and federal tax money was custodial and little was being done to lighten this load. It is debateable whether healthy ambulatory elderly people require domiciliary care in public institutions.

In our report to the medical profession last January we recommended an intensive medical program for a time as a means of proving that real remedial or palliative care could be given that would lessen the cost of prolonged incapacity as now conducted. We urged (a) better and more frequent physical examinations by the town doctors, (b) Laboratory and diagnostic tests in the adjacent tumor clinics or detection clinics, (c) enlarging the convalescent wings of all state aided hospitals for the temporary care of cases that might be assisted to become self-sustaining, (d) the establishment under the auspices of the Commission of a special study unit for intensive training of physicians in such fields as seem most likely to be effective in postponing deteriora-



ion such as cardiac disease, hypertension, arthritis, cancer and certain neurological conditions.

About the time our report was made the Veterans' Hospital Commission had made a survey of their future needs and offered some beds now in surplus for our program. This was a remarkably happy solution because Rocky Hill has one of the largest and best equipped hospitals in the state. While some of the work done there was on acute cases, the greater portion was much the same in character as we contemplated. Further, there were beds to spare in a readily accessible central location. Unfortunately, we will only be able to care for male cases at Rocky Hill and we will still have to provide for female cases at Hartford or New Haven.

Since the state raised the fees paid general hospitals for patient care, it may be possible to increase the numbers of beds in those institutions available for chronic patients so that the burden of finding nursing and professional care for so many such cases may be lightened.

This seems an inappropriate time to favor new construction, nor will the funds of our Commission be used for building new wards. However, some Hill-Burton bill funds may soon be available and some wards now closed may be reopened if we can more nearly pay full cost for patient care than has hitherto been possible.

Housing of healthy ambulatory aged and infirm is still a local problem and we hope to advise cities, boroughs and towns to provide such facilities in light of modern social concepts and not as heretofore in the "town poor house or poor farm." Our funds will not be used for housing simple custodial cases who are able to care for themselves.

The proper conduct of our program rests on the cooperation we receive from the medical profession and our allies the physio-therapists, nurses and chemical technicians. A subcommittee of the two commissions involved, consisting of Dr. Charles Sprague, Dr. Joseph Howard and Col. Gates are now receiving applications for both full-time and part-time physicians to conduct special studies in cardio-reno-vascular disease, arthritis, cancer and neurology. We contemplate establishing a complete staff and maintaining a resident training so that interns, junior medical officers and senior medical officers will be able to qualify for their specialty boards. The rates of pay are similar to those provided by the Veterans' Administration. Complete physiological chemical laboratories and radiation therapy will be maintained. The hospital at Rocky Hill will be opened sometime in October and cases will be admitted as selected from all over the state which offer some hope for remedial or palliative care. Their stay will be limited to six weeks to two months.

## SEMI-ANNUAL COUNTY ASSOCIATIONS MEETINGS

Fairfield, Wednesday, October 1

WEE BURN COUNTRY CLUB, DARIEN

Golf tournament (tee-off between noon and 1:00 P. M.) Business meeting 4:30 P. M.

Followed by social hour, dinner at 7:00 P. M.

*Guest Speaker:* Franklin P. Adams, author and columnist*Subject:* To be announced

New London, Thursday, October 2

SEASIDE SANATORIUM

4:30 P. M.

Business meeting, dinner

Speaker to be announced

Litchfield, Tuesday, October 7

TORRINGTON COUNTRY CLUB, GOSHEN

Social hour 5:00 P. M.

Dinner 6:00 P. M.

Business meeting 7:00 P. M.

*Speaker:* John C. Leonard, M.D., Hartford*Subject:* PRACTICAL ASPECTS OF THE TREATMENT OF HYPERTENSION

Middlesex, Thursday, October 9

EDGEWOOD COUNTRY CLUB, CROMWELL

Business session 4:00 P. M.

Dinner 6:00 P. M.

*Speaker:* Harris B. Shumacker, Jr., M.D., associate surgeon, New Haven Hospital*Subject:* INDICATIONS FOR AND TECHNIQUES OF SYMPATHECTOMY



Windham, Thursday, October 16

PUTNAM COUNTRY CLUB, PUTNAM

12:30 P. M.

Speaker to be announced

Tolland, Tuesday, October 21

OLD HOMESTEAD INN, SOMERS

6:30 P. M.

Dinner precedes meeting

*Speaker:* Edward T. Whalen, M.D., Hartford

*Subject:* EAR, NOSE AND THROAT PROBLEMS OF GENERAL PRACTICE

New Haven, Thursday, October 23

WATERBURY COUNTRY CLUB

Business session 5:00 P. M.

To be followed by dinner at 6:45 P. M.

Speaker to be announced

Hartford, Tuesday, October 28

INDIAN HILL COUNTRY CLUB, NEWINGTON

Golf tournament 1:00 to 5:00 P. M.

Business session 5:00 to 5:30 P. M.

Social hour until dinner at 7:00 P. M.

*Speaker:* LeMoyne Snyder, Bureau of Investigation, State of Michigan

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New London: Clarence G. Thompson, <i>Norwich</i>
Tolland: Leonard W. Levine, <i>Ellington</i>
Windham: Brae Rafferty, <i>Willimantic</i>
Yale School of Medicine: Arthur J. Geiger

## EDITORIALS

### The Trend Toward Socialism

Many people believe that mankind inevitably will be carried to a system of totalitarian government under which all affairs will be managed by omnipotent dictators. Others believe that there is some sort of reasonable Middle Way by which individual freedom can be "mixed" with socialism. "On the surface," says Dr. Leonard E. Read of the Foundation for Economic Education, "events appear to have borne out the contention that this expropriation or 'socialization' of property might take place peaceably, that is, without armed revolution and civil war. But a closer view reveals that erosion of liberty throughout the world resulted in the two bloodiest wars of all history . . . Starting in Germany some sixty years or more ago, the 'interventionism' has grown in popularity in one country after another throughout the world. As *Sozialpolitik*, the Welfare State, a New Deal, or Economic Planning, it is preached and promoted in churches, schools, farm organizations, and business associations as the 'non extremist, reasonable Middle Way'." In a recent book entitled *Planned Chaos*, Professor Ludwig von Mises of New York University points out why the popularity of this policy is not a safe test of its soundness, why it fails in its avowed purposes and what it does to nations which pursue it. He points out the steps by which a state of affairs is produced which is worse than that which it was designed to correct. First the Government intervenes; then, faced with the failure of this intervention, the Government adds "to its first

measure more and more regulations and restrictions. Proceeding step by step on this way, it finally reaches a point in which all economic freedom of individuals has disappeared. Then socialism of the German pattern, the *Zwangswirtschaft* (compulsory economy) of the Nazis, emerges." In considering the alleged inevitability of socialism, this writer points out that the course of human affairs is determined by ideas and that what is needed to fight socialism and despotism are ideas embracing common sense and reflecting moral courage.

It should be plain that socialism cannot be fought effectively by criticizing but some of its features any more than it can be defended by praising but some of its alleged achievements. It will be remembered that many of our countrymen at the beginning of the Fascist regime in Italy convinced themselves of its merits because the trains of that country were on time. With a similar lack of intelligence there are those who, annoyed or inconvenienced by the actions of capital and labor in this country, believe that the government should intervene and outlaw all strikes. They should be reminded that there are no strikes in the totalitarian state.

The problems of society's organization cannot be dealt with in any such superficial manner. They require deep study and cannot be discussed lightly. Public opinion must, therefore, be remoulded by those who indulge in straight and fearless thinking. Unless this is accomplished, the victory of socialism will be inevitable because of a spirit of cynicism



and defeatism which will develop in the mass of the people.

The object lesson which a socialized Europe is now presenting should be sufficient for any American to resolve that there will be no further extension here. The physicians of our country should become acutely aware of what is happening to their colleagues in Great Britain, for the present regulatory measures, unless halted, surely will be compulsory tomorrow.

The greatest vision that man has yet experienced is known as the Brotherhood of Man, but the Great Proponent of that magnificent idea certainly did not envisage that the Golden Rule of Conduct could be brought into universal adoption by the methods of the firing squad.

"The time has come," says Lecomte du Noüy in his remarkable book, *Human Destiny*, "for all men of good will and of good faith to become conscious of the part that they can and must play in life, if our present Christian civilization is to endure."

### Who Leads?

If the question, "Which is the leading medical community in the state?", were asked, interesting replies would be received depending upon whom the question was put to and where. Also, it would depend upon what standards of appraisal were applied. From the standpoint of the Society, a way of looking at it would be comparative participation in the Building Fund. When that is done, New London comes out conspicuously in the top position.

Seventy-five per cent of the physicians in New London have contributed to the Fund as compared with forty-six per cent for the state as a whole. The average individual contribution in New London is \$97.80, for the state \$63.50. New London has been generous.

The Board of Trustees of the Fund and all others interested in the building project cannot help but wish that the rest of the state would respond as New London has. If it was like that, there would be seventeen hundred and thirty-five contributors instead of ten hundred and fifty-nine and the total sum available would be over \$170,000.

Meriden is a close runner-up to New London for top place, when the gift in honor of Dr. Edward Bradstreet, which was announced last month, is included. The JOURNAL congratulates both cities.

### Government and Scientific Research

Last month the President's Page in the JOURNAL commented upon the veto of the National Science Foundation bill by President Truman. The reason Mr. Truman ascribed for his veto was that the bill established the Foundation outside of direct executive, that is to say, political control. The Presidential veto on this basis should be of great concern to American science.

A good deal can be learned from the experience of a similar project in Great Britain. In that country a Medical Research Committee was established under the National Health Insurance Act in 1913 and this Committee engaged in productive medical research during World War I. In 1919, the project was transferred to a Committee of the Privy Council and in 1920 it received its present title, Medical Research Council and a constitution of its own. It is financed directly from grants from the Treasury and by private gifts. Dr. H. H. Clegg, editor of the *British Medical Journal* describes the constitution of the Medical Research Council as follows:

"It is made up of eleven members, eight of whom are chosen for their scientific and medical qualifications. Of the other three, one must be a representative of the House of Lords, and one of the House of Commons. Members of the M.R.C. are appointed by the Committee of Privy Council for Medical Research, after consultation with the President of the Royal Society and with the M.R.C. itself. The principal official of the M.R.C. is the secretary—at present Sir Edward Mellanby, F.R.S.—and he is elected by the M.R.C. itself and not by the Committee of Privy Council for Medical Research, to which he is also secretary. This means that the eight scientific and medical members of the M.R.C. decide who is to hold the highly important post of directing medical research under States auspices. This rule of election removes the risk of political influence and interference with the work of the M.R.C., and the fact that its secretary is also secretary of the Privy Council Committee ensures that there is no bureaucratic buffer between the M.R.C. and the Lord President of the (Privy) Council, who is the Minister responsible to Parliament for the work of the M.R.C.

"In these ways State interference in a State financed project is reduced to a minimum, and the fullest scope for action is granted to the M.R.C., which is not only an advisory body but has com-

plete executive control of the funds at its disposal. Each member of the M.R.C. holds office usually for four years, and on retirement cannot be reappointed immediately. This ensures that the M.R.C. does not become static in the hands of permanent authority."

There would appear to be wisdom in this arrangement, for large private benefactions have been attracted from the Leverhulme Trustees, the Rockefeller Foundation, and other sources. Such private donations are not attracted to institutes which are under political control of the kind which President Truman apparently prefers. The M.R.C. maintains its own national institute for medical research, the contributions of which have been known to scientific men the world over.

Dr. Clegg states that no one has raised a voice against the idea that the State should finance medical research. In spite of widespread criticism of the government controlled plan for medical care in England, the profession has not raised a voice against the idea that the State should finance medical research. This approval, no doubt, reflects the wisdom and skill with which government has coordinated the interest of private and official scientific investigation leaving control to the Council itself without political interference.

Perhaps the insistence on strict political control which President Truman feels is essential is one of the reasons why American scientists distrust government domination. It is to be hoped that members of Congress will study the successful organization of the British Medical Research Council and that our own National Science Foundation may learn from its many years of fruitful operation.

### The Practical Nurse

Mable I. Darrington, R.N., in the July issue of *Cincinnati Journal of Medicine* calls attention to the fact that for the past thirty years the national organizations have been advocating the preparation of practical nurses but the nurses themselves have done very little about it. In 1916 the American Hospital Association, after a study by a special committee, advocated the preparation of a worker to care for the sick and the home. In 1919 the Committee on Nursing of the General Medical Board of the Council of National Defense recommended that the three National nursing organizations take over the training of attendants and regulate their practice. In 1923 a national survey resulted in

recommendations for the immediate recognition of this group and definite recommendations for training, licensing and supervising them. In 1928 the first report of the Committee on the Grading of Nursing Schools supplies strong arguments in favor of using trained attendants. The Committee on Costs of Medical Care in 1930-1932 called the situation acute at that time and recommended licensure for nursing aids and attendants. The National Health Survey in 1935 added more evidence for the need of such trained attendants in caring for chronic illness. Several State Nurses' Associations between 1935 and 1940 studied the situation and recommended licensing and supervising of practical nurses.

So it is not a new problem but the recent war has created a much broader understanding of the need and, at least according to Miss Darrington, a more realistic acceptance of the situation. State legislative control would seem to be an indispensable preliminary step to establishing schools for the preparation of practical nurses. Four states, however, have schools approved by the National Association for Practical Nurse Education without a state law to control their practice. It would seem to be high time after all these thirty years of discussion of the need for the practical nurse that medicine and nursing and government sit down together and establish a uniform method of training and registration of the practical nurse in every state and territory of these United States. Instead of nineteen states and the Territory of Hawaii licensing some type of nonprofessional worker who may nurse for hire under a variety of titles, we then should have a standardized training, a uniform law for registration, and a common title recognized throughout the United States. Incidentally we might hear less that prevalent complaint from the hospital patient, "I can't get anything done for me; the nurses are too busy."

### Spare Parts?

When a man dies, it means that a part has worn out.

Henry Ford\*

The mechanism of decay and death is not quite so simple as Henry Ford's dictum suggests, and it is hardly rational to liken the human body to a "Model T" or even to one of Henry's more recent de luxe vehicles. And yet the quotation contains

\*Quoted by John Gunther, *Inside U. S. A.*



more than a modicum of truth. Years ago that thoughtful and astute observer James Paget wrote an essay entitled "Errors in the Chronometry of Life" in which he pointed out that all parts of the human frame do not deteriorate synchronously and that, indeed, individual variations in the rate of wear and tear are to some extent hereditary. In his monograph on Angina Pectoris, William Osler cited the Hughes family (Tom Brown's School Days, etc.) as being abnormally vulnerable to coronary artery disease, and there are some families too, to mention just another example, whose members tend to "wither at the top." As illustrations of the minor manifestations of aging, we all know clans whose members develop gray hair or senile skin changes much earlier than average people.

If our tissues and organs all aged at the same rate and all disintegrated at the same moment we would doubtless meet the fate of Oliver Wendell Holmes' wonderful one hoss shay and die, perhaps like one of Dickens' characters, of spontaneous combustion. But nature, aided and abetted by human disregard of the rules of the game of life, doesn't work that way. If it is mere longevity one is aiming at, the main necessity, according to Raymond Pearl, is to pick out a group of long-lived ancestors. Having arranged this, one may smoke or not smoke, drink or not drink and, in general, live a reasonably hygienic or unhygienic life and get away with it.

Aside from the mortality due to neoplasms and the infections, the latter often merely terminal events ending chronic diseases, many of us do die because some particular part has worn out. This statement is obviously an oversimplification in that it suggests that simple mechanical wear and tear are responsible. Throughout life our tissues are subjected to adverse conditions in the form of toxic insults from major or minor infections, from substances purposively or accidentally consumed with food or drink, from tobacco, and even at times from medicine. Indeed, we know quite well that our own malfunctioning organs may produce substances capable of causing considerable damage, just as in a Model T the wastes of combustion are a factor in the etiology of obsolescence. And, it may be added, we are now acutely aware of the effect of psychic stresses.

Were it not that prophets have always been unduly liable to get into hot water, one would be tempted to hazard some guesses as to the possibility of bodily repairs and replacements in the future.

Modern surgery has developed to a point where it can correct some malformations, notably circulatory ones, until recently beyond its reach, and invade organs, the lungs, heart and brain for example, that were formerly regarded as sacrosanct. To a limited extent we can now supply missing parts, but whether we shall ever reach a stage in which diseased vessels or damaged organs can be commonly replaced in whole or in part is a moot question. An affirmative answer would mean that the personal columns of our newspapers would be more intriguing than ever. It would be diverting to read that Jane Doe had just returned from the Juneau Clinic with a new aorta or that Jane Roe had acquired a new archipelago of Islands of Langerhans at Mount Ararat Hospital. To be realistic, the likelihood of such performances seems rather remote but—quien sabe?

G. B.

### Medical Practice and Undergraduate Medical Education

In a recent discussion of this subject Dr. D. W. Clark emphasizes the important influence that medical practice has, and of necessity must have, on a medical education. That such education will be conditioned by the main trends in medical practice, calls for a careful study and evaluation of such trends, a problem of considerable magnitude. His recommendation that the talents of a medical school faculty could be well directed toward this end is a logical proposal. Dr. Clark goes further and suggests that the medical school also has a responsibility in fostering experiments in methods which will enhance the effectiveness of medical practice. His remarks on training as it applies to the practice of general medicine and of specialization are very pertinent at a time when these forms of practice are the subject of so much discussion.

### Connecticut Loses a Friend

The death of Robert N. Nye of Boston on September 10 came as a shock to his friends in Connecticut. Bob Nye was a hard worker for organized medicine as well as a valuable teacher of pathology at his alma mater. As managing editor of the *New England Journal of Medicine* he showed his ability in carrying on the standards set by his predecessor, the late Dr. Walter P. Bowers. In addition to this important position he was associate pathologist at

Boston City Hospital and assistant professor of pathology at Harvard Medical School.

Many other important posts were held by Dr. Nye. During the recent war he was a member of the committee on information of the National Research Council, and a member of the committee on information, procurement and assignment service of the War Manpower Commission. He was an editor of *War Medicine*, published by the American Medical Association; councilor of the Massachusetts Medical Society; trustee and treasurer of the Boston Medical Library; councilor of the Harvard Medical Alumni; and a director-at-large of the Massachusetts Tuberculosis Association.

His genial smile will be greatly missed by all who were fortunate enough to claim his friendship.

### Announcement of New Post Graduate Seminars

The attention of Connecticut physicians is directed to new post graduate seminars which will be given in the coming months. These and similar projects are examples of the efforts which are being made at the Yale School of Medicine to extend further the field of that institution's usefulness in bringing to graduates in medicine opportunities for keeping up to date in the newer developments of medical science. The continued success of the fine cooperative enterprise which we know as the Clinical Congress insures an enthusiastic reception for these newer projects. Dr. Yakovlev of the Connecticut State Hospital at Middletown who is Curricular Secretary of the Connecticut Post Graduate Seminar of Neuropsychiatry brings to that field a wide and successful experience in similar endeavors elsewhere. Dr. Williams who will share important responsibilities in the conferences on infertility is well known in this state as a high authority in this subject.

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### Conference On Infertility Problems

The Yale University School of Medicine announces a series of six conferences on infertility problems to be given at the New Haven Hospital one afternoon each week, beginning Tuesday, November 4, 1947. The course is under the direction of the Department of Obstetrics and Gynecology, and will be given by Dr. W. W. Williams of Springfield, Massachusetts, and other authorities

in this field. Physicians desiring to avail themselves of this opportunity are requested to write to Dr. Herbert Thoms, in care of the Yale School of Medicine. There will be no registration fee.

### Arkansas Selects Life Insurance Company to Write Prepayment Health Care Plan

Of interest to Connecticut physicians because of the similarity to the plan being formulated in this State should be the new Arkansas health care prepayment program. Certain specifications were set up and bids invited from the ninety-six companies authorized to write health insurance in Arkansas. Ten companies signified interest but only one, the John Marshall Insurance Company, met the specifications in full and was awarded official approval of the joint committee of the Arkansas Medical Society and the Arkansas Hospital Association. This approval of one company does not prohibit other companies from selling any form of health and hospital insurance in Arkansas.

Certain features of this health care prepayment program are noteworthy. In order to make it easier for the people of Arkansas to obtain the health care they need, the John Marshall Company places emphasis on enabling the provision of health care rather than on indemnifying policy holders for losses resulting from sickness or accident. It does not, for example, require health statements, impose age limits for membership, exclude pre-existing or chronic conditions, or otherwise refuse membership to those who may need health care most. The Company maintains no claims department but depends on the individual physician's judgment for determination of the patient's need for care.

The program is planned to make available to its subscribers the following coverages: comprehensive surgical-obstetrical, comprehensive hospital, and standard hospital. Rates run from fifty cents for one person and \$1.25 for a family per month in the Standard Hospital coverage to ninety cents for one person and \$2.25 for a family per month under comprehensive hospital coverage. It is contemplated, at least in the beginning, to make the new plan available only through employed and other established groups such as Farm Bureaus and cooperative organizations. Because the John Marshall is a national company, members of the Arkansas plan will receive uniform benefits wherever they may require hospital care.



## THE PRESIDENT'S PAGE

**I**T is one of our common failings, after working successfully for the passage of a particular law, to relax confident that somehow the mere existence of it will bring about the desired result.

We do the same thing when we appoint committees. The committee is a standard device for delegating responsibility in any representative democracy. It is a method of expediting the will of the governing body, whether it be to explore new fields, to review accomplishments or to direct future progress. The committee does not meet its objectives if it does not expedite and aid the purposes of the governing body.

It is essential that persons selected for committee assignments be capable, interested and diligent and that in addition they have a clear understanding of the aims, scope of authority and duties of the committee. The first of these duties is for the committee to organize itself and adopt a plan of activity. This plan should be presented to the appointing authority promptly and periodic reports of work done should be given, for no coach-and-four can be guided successfully unless the reins are well held.

The progress of our Society depends largely on the continuous and intelligent activity of its many committees. This is a call for a full realization of that responsibility.

James R. Miller

## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

### Meetings Held During September

Wednesday, September 24, 4:00 P. M.

Committee to Study Maternal Morbidity and Mortality

Monday, September 29, 5:00 P. M.

Trustees of the Building Fund

### Meetings Scheduled for October

Thursday, October 2, 3:00 P. M.

Committee on Public Health

Friday, October 3, 4:00 P. M.

Council of the Society

### Connecticut Rural Health Surveys

The Society's Committee on Rural Medical Service has been engaged, since its appointment just over a year ago, in the compilation of information on the nature and extent of medical health needs of the rural population of Connecticut. To this end, two opinion surveys have been made under the direction of the Committee and the data which have been obtained provide adequate basis for a preliminary report.

The Committee sought first to determine professional opinions on the availability and adequacy of medical service in farm areas of the state. Questionnaires were sent to more than 300 physicians engaged in predominantly rural practice and approximately 25 per cent completed and returned the forms. The uniformity of the replies to the majority of the questions, although it was perhaps to be expected, was nonetheless striking.

It was the consensus that the number of general practitioners in small towns and outlying districts was sufficient to meet patient needs and that, with one or two debatable exceptions, settlement of specialists in these areas was not indicated. In this compact, populous state, services of highly trained specialists are accessible in urban centers which are within reasonable travelling distance from all sec-

tions, and location in larger communities is logical and necessary because of the convenience of essential diagnostic facilities and services and of opportunities to increase professional knowledge and proficiency.

The supply of hospital beds for the treatment of acute cases was held in nearly every reply to be adequate and similar agreement was expressed on the value of extension of the Blue Cross Plan for prepayment of hospital expense. A companion question concerning the attitude of patients towards prepayment for medical care was of importance because of the intensive work of the Society on the development of a prepaid plan to cover the costs of medical and surgical care. Ninety-five per cent of the respondents said that they have not been queried by patients but in each instance they expressed the belief that this was due to lack of information and familiarity with the advantages of voluntary sickness insurance. In this respect, the opinion of the non professional groups covered in the second survey tallied exactly with that of the doctors and emphasized sharply the necessity for widespread public education in this field.

A belief that public health services in the smaller communities should be augmented was general but in response to a sequential question concerning community interest in district health units, it was stated that although there was no apparent popular support or enthusiasm for such a cooperative effort, this was in all likelihood again to be ascribed to insufficient understanding and recognition of its advantages.

Inadequate community health education programs were reported in 80 per cent of the questionnaires, several of which stated that the public health nurse was the only person giving any instruction to the people. It is fair to conclude from the data that this common defect in the health program derives from shortage of personnel and not from failure to realize its importance.

The final question, which concerned the fre-



quency and completeness of school health examinations provided the sole instance of marked divergence of opinion in the physician group. About fifty per cent held the view that examinations should be done yearly and the remaining half think that yearly physical examinations are neither practical nor necessary. These varying points of view are found generally, not in reference to the kind and frequency of examinations alone, but in regard to the school health program as a whole. A pattern for school health programs which is universally acceptable has yet to be developed.

In its second study, the Committee on Rural Medical Service undertook to determine consumer opinions on medical and public health services in rural areas. This poll was also conducted by questionnaires which were somewhat more detailed than those used for physicians.

Five hundred forms were sent to civic groups which are close to community problems. Among these were included Parent-Teacher Associations in towns of under 10,000 population, local Granges, Homemakers Clubs of the Agricultural Extension Service and Women's Clubs. The Committee asked that each organization devote a meeting to discussion and completion of the questionnaire in order that the information furnished might represent group rather than individual thinking.

It was clearly apparent that considerable care had been given to formulating the replies in the one hundred and four queries which were returned, and in this series also the agreement among the answers was notable. A shortage of general practitioners was claimed for only twelve towns, one of them with a population of 250! In two or three instances, there is some evidence that an additional doctor is needed, but in each case, economic factors must be considered. It is hardly practical to expect a physician to locate in an area where the possibilities of realizing an adequate income are slight and opportunities for professional contacts are few.

Lay groups participating in the survey recognize the circumstances which lead to concentration of specialists in urban centers and are accustomed to travelling to nearby cities to obtain their services. They are also unanimous in their advocacy of Blue Cross which has been made available to a substantial number of farm people through enrollment of Farm Bureau and Grange members. Nearly all of the respondents said that they were not aware of interest in a voluntary prepaid medical care plan but quali-

fied the answer, as did the physicians, by adding "People don't know enough (or anything) about it."

The number of hospital beds for acute cases was thought by the consumer group to be sufficient but only one negative reply was obtained to the question: "Is there a need for institutions for the chronically ill?" The rural population are quite as cognizant of one of our State's most pressing medical care problems as are city dwellers.

A section on fees for office, home day and night calls was a part of the second survey form. The most frequently reported fee for office was \$3, fees charged for home calls during the daytime ranged from \$3 to \$8 with the average \$5, and those for night calls varied from \$5 to \$10 with the average \$7. It should be pointed out that, although some of these fees, especially those for night calls, appear high, the amount of travel involved cannot be discounted nor can an understandable attempt to discourage unnecessary calls be condemned.

Opinion on the costs of medical care in comparison with other living expenses has particular significance in view of the foregoing data on charges. According to two-thirds of the replies, the costs of medical care have risen but only in proportion to the rise in all other costs. This eminently reasonable reaction is encouraging, especially at a time when clamorous accusations of over-charging by physicians are the order of the day.

Although the majority of physicians doubted the existence of interest in district health units, just under 50 per cent of the lay groups believed that there is such an interest and that the establishment of units with full time trained personnel is the method of choice for improving public health service in farm areas. The balance did not express opposition to the district health plan but only lack of information about it.

All of the replies emphasized the value of public health nursing services and more than fifty per cent would like to have additional nurses serving their areas. They agreed also, as would be predicted in a group containing a high proportion of parents, that school health services should be extended.

The results of these two surveys are instructive not only for the Committee on Rural Medical Service but for all the members of the Society. They provide the basis for continued investigation by the Committee and for the ultimate correction of defects in the medical and public health services available to the rural population of the State.

## New Law for Compulsory Education of Deaf Proposed

A proposal that the State of Connecticut enact a law for the compulsory education of the deaf through the eight primary grades was voiced by Alan Crouter, superintendent of the Mystic Oral School, at the first meeting of the new sub-committee on Hearing of the Society's Public Health Committee. The meeting was held at the Graduates' Club, in New Haven, on July 30.

Also present as a guest speaker was Edmund B. Boatner, superintendent of the American School for the Deaf, Hartford, who told committee members that a serious problem exists in securing an adequate number of properly trained teachers for the deaf. Only four training schools in the country supply teachers for these institutions, he said.

Members present were Norton Canfield, M.D., associate professor of otolaryngology, Yale University School of Medicine, and chief of audiology, Veterans Administration, chairman of the committee; Edward H. Truex, Jr., M.D., associate in otolaryngology, Hartford Hospital; P. W. Snelling, M.D., consultant in otolaryngology, Hartford Hospital; Frederick N. Sperry, M.D., attending otolaryngologist, New Haven Hospital, honorary committee chairman; and J. Donald Harris, Ph.D., acoustic physicist at the New London Submarine Base, and consultant for the committee.

In explaining the aims and purposes of the new committee, Dr. Canfield stated that it will act as an advisory group to the Public Health Committee, now under the chairmanship of Maurice J. Strauss, M.D., associate clinical professor of dermatology, Yale University School of Medicine, and attending physician in dermatology, New Haven Hospital.

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 Samuel C. Harvey, 789 Howard Ave., New Haven  
 Andrew J. Jackson, 111 West Main St., Waterbury  
 Stephen L. Lirot, 147 West Main St., Meriden  
 Ralph E. McDonnell, 158 Whitney Ave., New Haven  
 M. Heminway Merriman, 115 Prospect St., Waterbury  
 Samuel B. Rentsch, 61 Seymour Ave., Derby  
 Walter I. Russell, 317 Whalley Ave., New Haven  
 Charles I. Solomon, 147 West Main St., Meriden  
 Thomas J. Sullivan, 495 Orange St., New Haven

#### New London County

Mario J. Albamonti, 257 Main St., Norwich  
 Charles G. Barnum, 230 Thames St., Groton  
 Casimer E. Bielecki, 35 Main St., Norwich  
 Thomas Soltz, 52 Huntington St., New London

#### Tolland County

Wendelin G. Luckner, Stafford Springs

#### Windham County

Cecil R. Carcin, 7 Broad St., Danielson  
 Brae Rafferty, 807 Main St., Willimantic

### Standing Committees

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Francis G. Blake, 789 Howard Ave., New Haven, *Chairman*  
 Herbert Thoms, 789 Howard Ave., New Haven, *Secretary*  
 Cole B. Gibson, Undercliff, Meriden, *Treasurer*  
 President of the Society  
 Chairman of the Council  
 Executive Secretary of the Society  
 Editor of the JOURNAL  
 Eight Secretaries of the component County Medical Association  
 Such other members as the Committee shall appoint

#### EDITORIAL BOARD (one elected annually for four years)

Stanley B. Weld, 54 Church St., Hartford, *Editor-in-Chief*  
 1944 Frank S. Jones, 179 Allyn St., Hartford  
 1945 Herbert Thoms,  
 789 Howard Ave., New Haven, *Literary Editor*  
 1946 Paul P. Swett, Gun Mill Road, Bloomfield  
 1947 Benjamin V. White, 701 Asylum Ave., Hartford  
 Associate Member: Harold S. Burr,  
 333 Cedar St., New Haven

#### COMMITTEE ON HONORARY MEMBERS AND DEGREES (elected annually for three years)

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 179 Allyn St., Hartford, *Chairman*  
 1946 Joseph H. Howard, 144 Golden Hill St., Bridgeport  
 1947 Cole B. Gibson, Undercliff, Meriden

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 1947 Maurice T. Root, 51 North Main St., West Hartford  
 Associate Member: John F. Fulton,  
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 Clair B. Crampton, 119 Main St., Middletown  
 Gilbert R. Hubert, 24 Church St., Torrington  
 Alfred Labensky, 85 Federal St., New London  
 Joseph I. Linde, City Hall, New Haven  
 William H. McMahon, 13 Washington St., South Norwalk  
 L. Rogers Morse, Cedarcrest, Hartford  
 Luther K. Musselman, 107 Whitney Ave., New Haven  
 Karl T. Phillips, 66 Main St., Putnam  
 J. Harold Root, 103 North Main St., Waterbury  
 Oliver L. Stringfield, 1416 Bedford St., Stamford  
 Alfred B. Sundquist, 11 Oak St., Manchester  
 Carl L. Thenebe, 720 Farmington Ave., West Hartford  
 Associate Member: Friend L. Mickle, Box 1139, Hartford

#### COMMITTEE ON PUBLIC RELATIONS

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Thomas J. Danaher, 100 Litchfield St., Torrington  
 Goerge H. Gildersleeve, 310 Main St., Norwich  
 Averill A. Liebow, 310 Cedar St., New Haven  
 Brae Rafferty, 807 Main St., Willimantic  
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 Middlesex: Richard F. Grant, 221 Main St., Cromwell  
 New Haven: Charles T. Flynn,  
 41 Trumbull St., New Haven  
 New London: Edmund L. Douglass,  
 188 Thames St., Groton, *Chairman*  
 Tolland: Leonard W. Levine, Ellington  
 Windham: Brae Rafferty, 807 Main St., Willimantic  
 President of the Society  
 Executive Secretary

COMMITTEE ON HOSPITALS (Two members elected annually for a term of three years)

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 1945 Robert R. Nesbit,  
 Hospital of St. Raphael, New Haven, *Chairman*  
 1946 William H. Curley, 881 Lafayette St., Bridgeport  
 1946 James C. Fox, Jr., Hartford Hospital, Hartford  
 1947 Harold W. Wellington, 309 State St., New London  
 1947 Albert W. Snoke, 789 Howard Ave., New Haven

COMMITTEE ON MEDICAL EXAMINATION AND MEDICAL EDUCATION (The Connecticut Medical Examining Board) (Member elected annually for a term of five years)

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 183 Bishop St., New Haven, *President*  
 1944 Thomas P. Murdock, 147 West Main St., Meriden  
 1945 John D. Booth, 173 Main St., Danbury  
 1946 George M. Smith, 333 Cedar St., New Haven  
 1947 Wilmot C. Townsend, 301 Farmington Ave., Hartford

COMMITTEE ON NATIONAL LEGISLATION (Elected for a term of one year)

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 Ralph M. Tovell, 20 South Hudson St., Hartford  
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 Chairman, Committee on Public Policy and  
 Legislation (ex-officio)  
 Delegates to the A.M.A. (ex-officio)

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 Bernard S. Dignam, 133 Pearl St., Thompsonville  
 John N. Gallivan, 74 Connecticut Blvd., East Hartford  
 Albert S. Gray, 1179 Main St., Hartford

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 Andrew J. Jackson, 111 West Main St., Waterbury  
 John F. Kilgus, 80 West St., Litchfield  
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 Philip J. Moorad, 55 West Main St., New Britain  
 Frank T. Oberg, General Electric Co., Bridgeport  
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 Crit Pharris, United Aircraft Corp., East Hartford  
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 Louis G. Simon, 58 South Main St., South Norwalk  
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Station A, Drawer K, Hartford

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 Executive Secretary, ex-officio  
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 Raymond A. Gandy, 5 South St., Stamford  
 Michael E. Giobbe, 355 Prospect St., Torrington  
 Donald J. McCrann, 50 Farmington Ave., Hartford  
 Edward J. Ottenheimer,  
 Windham Community Hospital, Willimantic

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 President of the Connecticut Medical Examining Board  
 Chairman of the Committee on Public Policy and Legislation  
 James R. Miller, 179 Allyn St., Hartford  
 Herbert Thoms, 789 Howard Ave., New Haven

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 Arthur J. Geiger, 240 Bradley St., New Haven  
 Averill A. Liebow, 310 Cedar St., New Haven  
 Donald B. Wells, 580 Asylum Ave., Hartford  
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 Norton Canfield, 789 Howard Ave., New Haven  
 Joseph N. D'Esopo, 33 Whitney Ave., New Haven

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 C. Frederick Yeager, 178 Jackman Ave., Bridgeport  
 Creighton Barker, 258 Church St., New Haven

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 David H. Bates, 28 Front St., Putnam  
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 William H. Upson, 172 Main St., Suffield  
 James F. Ferguson, 176 North Main St., Wallingford

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 Clair B. Crampton, 119 Main St., Middletown  
 James C. Fox, Jr., Hartford Hospital, Hartford  
 Louis F. Middlebrook, Jr., 293 Farmington Ave., Hartford  
 Ralph M. Tovell, 20 South Hudson St., Hartford  
 Associate Member: Ira V. Hiscock,  
 310 Cedar St., New Haven

### ADVISORY COMMITTEE TO THE BOARD OF TRUSTEES OF THE BUILDING FUND

Hugh B. Campbell, 275 Broadway, Norwich  
 Thomas P. Murdock, 147 West Main St., Meriden  
 Herbert Thoms, 789 Howard Ave., New Haven, *Chairman*

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Joseph H. Howard,  
 144 Golden Hill St., Bridgeport, *Chairman*  
 Eric H. Blank, 240 Williams St., New London  
 Carl E. Johnson, 364 Oak St., New Haven  
 Norman C. Margolius, 50 Holmes Ave., Waterbury  
 Charles H. Peckham, 875 Main St., Manchester  
 Elizabeth C. Wells, Station A, Drawer K, Hartford

## COMMITTEE TO STUDY WORKMEN'S COMPENSATION LAWS

Thomas Soltz, 52 Huntington St., New London, *Chairman*  
 Ettore F. Carniglia, 50 Farmington Ave., Hartford  
 Clarence H. Cole, 111 West Main St., Waterbury  
 C. Louis Fincke, 1 Atlantic St., Stamford  
 John F. Kilgus, 80 West St., Litchfield

## COMMITTEE OF SIXTEEN TO STUDY THE ORGANIZATION AND OBJECTIVES OF THE SOCIETY

## Fairfield

Berkley M. Parmelee, 144 Golden Hill St., Bridgeport  
 Oliver L. Stringfield, 1416 Bedford St., Stamford

## Hartford

C. Charles Burlingame, 200 Retreat Ave., Hartford  
 Arthur B. Landry, 50 Farmington Ave., Hartford

## Litchfield

Floyd A. Weed, 199 Main St., Torrington  
 Thomas J. Danaher, 106 Litchfield St., Torrington

## Middlesex

Harold E. Speight, 70 Crescent St., Middletown  
 Frank H. Couch, Cromwell Hall, Cromwell

## New Haven

Herbert Thoms, 789 Howard Ave., New Haven  
 Courtney C. Bishop,  
 33 Whitney Ave., New Haven, *Chairman*

## New London

George H. Gildersleeve, 310 Main St., Norwich  
 Charles G. Barnum, 230 Thames St., Groton

## Tolland

Charles T. LaMoure, 16 Owen St., Hartford  
 William Schneider, 34 Union St., Rockville

## Windham

Karl T. Phillips, 66 Main St., Putnam  
 William Mac Shepard, 66 Main St., Putnam

## ADVISORY COMMITTEE TO THE STATE HEALTH DEPARTMENT ON PSYCHIATRY CLINICS

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 James C. Fox, Jr., Hartford Hospital, Hartford, *Chairman*  
 Arthur H. Jackson, Washington  
 Alfred Labensky, 85 Federal St., New London  
 Harry L. F. Locke, 179 Allyn St., Hartford  
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 William B. Terhune, Silver Hill, New Canaan

## COMMITTEE ON PREPAID MEDICAL SERVICE

James R. Miller, 179 Allyn St., Hartford, *Chairman*  
 Thomas P. Murdock, 147 West Main St., Meriden  
 Cole B. Gibson, Undercliff, Meriden  
 Herbert Thoms, 789 Howard Ave., New Haven  
 Joseph H. Howard, 144 Golden Hill St., Bridgeport

## MEDICAL ADVISORY COMMITTEE TO THE VETERANS PLACEMENT BOARD

Bliss B. Clark, 55 West Main St., New Britain, Surgeon  
 Russell V. Fuldner,  
 85 Trumbull St., New Haven, Orthopedist  
 Robert V. Nespor, 10 Taylor Pl., Westport, Internist  
 Charles I. Solomon,  
 147 West Main St., Meriden, Psychiatrist

Arthur C. Unsworth,

179 Allyn St., Hartford, Ophthalmologist

## COMMITTEE ON CHRONICALLY ILL

George A. Wulp,

50 Farmington Avenue, Hartford, *Chairman*  
 Richard I. Barstow, The Village Green, Norfolk  
 A. Nowell Creadick, 79 Trumbull St., New Haven  
 Clifford D. Moore, Stamford Hall, Stamford  
 Charles H. Sprague, 29 Hanover St., Bridgeport

## COMMITTEE ON HEALTH AND PHYSICAL EDUCATION

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 Paul Harper, Old Orchard Park, Fairfield  
 Derick A. January, 179 Allyn St., Hartford  
 Frank S. Jones, 179 Allyn St., Hartford  
 Joseph I. Linde, City Hall, New Haven  
 Katherine S. Quinn, 2970 North Main St., Bridgeport  
 Robert P. Rogers, 111 North St., Greenwich  
 James M. Sturtevant, 58 Huntington St., New London  
 Carl L. Thenebe, 720 Farmington Ave., West Hartford  
 Edward T. Wakeman, 129 Whitney Ave., New Haven  
 Associate Member: Ira V. Hiscock,  
 310 Cedar St., New Haven

## COUNTY SUB-COMMITTEE OF THE JOINT COMMITTEE OF THIS SOCIETY AND THE CONNECTICUT PHARMACEUTICAL ASSOCIATION

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144 Golden Hill St., Bridgeport

Hartford: W. Holbrook Lowell, Jr.,

703 Asylum Ave., Hartford

Litchfield: Thomas J. Danaher,

106 Litchfield St., Torrington

Middlesex: Norman E. Gissler, 164 Court St., Middletown

New Haven: Courtney C. Bishop,

33 Whitney Ave., New Haven

New London: Thomas Soltz,

52 Huntington St., New London

Tolland: Francis H. Burke, 45 Park St., Rockville

Windham: Brae Rafferty, 807 Main St., Willimantic

## SOCIETY'S REPRESENTATIVES—NEW ENGLAND POST-GRADUATE ASSEMBLY

Cole B. Gibson, Undercliff, Meriden

Stanley B. Weld, 179 Allyn St., Hartford

## DELEGATES TO THE COUNCIL OF NEW ENGLAND STATE MEDICAL SOCIETIES

Cole B. Gibson, Undercliff, Meriden

Joseph H. Howard, 144 Golden Hill St., Bridgeport

Harold E. Speight, 70 Crescent St., Middletown

## DELEGATES TO SPECIAL SOCIETIES (elected annually for term of one year) July 1, 1947—June 30, 1948

Connecticut Hospital Association:

Robert R. Nesbit, Hospital of St. Raphael, New Haven

Connecticut Pharmaceutical Association:

William T. Salter, 333 Cedar St., New Haven

Connecticut State Dental Association:

James R. Miller, 179 Allyn St., Hartford



DELEGATES TO STATE SOCIETIES FOR ONE YEAR July 1, 1947—  
June 30, 1948

Maine:

Stanley B. Weld, 179 Allyn St., Hartford  
Orville F. Rogers, 109 College St., New Haven

Massachusetts:

William J. German, 789 Howard Ave., New Haven  
Robert A. Goodell, 79 Elm St., Hartford

New Hampshire:

W. Holbrook Lowell, Jr., 703 Asylum Ave., Hartford  
George H. Gildersleeve, 310 Main St., Norwich

New Jersey:

George A. Buckhout, 144 Golden Hill St., Bridgeport  
Oliver L. Stringfield, 1416 Bedford St., Stamford

New York:

James R. Miller, 179 Allyn St., Hartford  
Cole B. Gibson, Undercliff, Meriden

Rhode Island:

Robert T. Henkle, 51 Federal St., New London  
William J. H. Fischer, 3 Lafayette St., Milford

Vermont:

Albert C. Freeman, 54 Broadway, Norwich  
Orpheus J. Bizzozero, 20 Grove St., Waterbury

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Vice-President: Clifford D. Moore,  
Stamford Hall, Stamford  
Secretary: George A. Buckhout,  
144 Golden Hill St., Bridgeport  
Treasurer: Clifton C. Taylor, 881 Lafayette St., Bridgeport  
Councilor: Berkley M. Parmelee,  
144 Golden Hill St., Bridgeport

### HARTFORD COUNTY ASSOCIATION

President: Louis P. Hastings, 114 Woodland St., Hartford  
Vice-President: Charles T. Schachtman,  
81 West Main St., New Britain  
Secretary-Treasurer: W. Holbrook Lowell, Jr.,  
38 Prospect St., Hartford  
Councilor: C. Charles Burlingame,  
200 Retreat Ave., Hartford

### LITCHFIELD COUNTY ASSOCIATION

President: Winfield E. Wight,  
24 Goodwin Court, Thomaston  
Vice-President: Frank L. Polito, 24 Church St., Torrington  
Secretary-Treasurer: Thomas J. Danaher,  
106 Litchfield St., Torrington  
Councilor: Floyd A. Weed, 199 Main St., Torrington

### MIDDLESEX COUNTY ASSOCIATION

President: Frank H. Couch, Cromwell Hall, Cromwell  
Vice-President: Philip E. Schwartz, 309 Main St., Portland  
Secretary-Treasurer: Norman E. Gissler,  
164 Court St., Middletown  
Councilor: Harold E. Speight, 70 Crescent St., Middletown

### NEW HAVEN COUNTY ASSOCIATION

President: Ralph E. McDonnell,  
158 Whitney Ave., New Haven  
Vice-President: Samuel B. Rentsch,  
61 Seymour Ave., Derby  
Secretary-Treasurer: Courtney C. Bishop,  
33 Whitney Ave., New Haven  
Councilor: Herbert Thoms, 789 Howard Ave., New Haven

### NEW LONDON COUNTY ASSOCIATION

President: Alfred Labensky, 85 Federal St., New London  
Vice-President: Henry A. Archambault,  
2 North Second Ave., Taftville  
Secretary-Treasurer: Thomas Soltz,  
52 Huntington St., New London  
Councilor: George H. Gildersleeve, 310 Main St., Norwich

### TOLLAND COUNTY ASSOCIATION

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Vice-Presidents: John P. Hanley,  
15 Church St., Stafford Springs  
Secretary-Treasurer: Francis H. Burke,  
45 Park St., Rockville  
Councilor: Charles T. LaMoure, Windham Center  
(16 Owen St., Hartford)

### WINDHAM COUNTY ASSOCIATION

President: Moses Margolick, 80 Main St., Putnam  
Vice-President: Reuben Rothblatt,  
672 Main St., Willimantic  
Secretary-Treasurer: Brae Rafferty,  
807 Main St., Willimantic  
Councilor: Karl T. Phillips, 66 Main St., Putnam

## THESE GAVE

### CONTRIBUTORS TO THE BUILDING FUND, AUGUST 10 - SEPTEMBER 15

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Curley, William H., Jr., Bridgeport  
Ogden, Faith N., Norwalk

#### LITCHFIELD COUNTY

Sanderson, Roy V., Winsted

#### NEW LONDON COUNTY

Haines, Henry L., New London

#### NEW HAVEN COUNTY

DuBois, Robert L., Waterbury  
Gcsell, Arnold, New Haven  
Harris, Benedict R., New Haven  
Kirby, Sam B., New Haven  
Piccolo, P. A., New Haven  
Rademacher, Everett S., New Haven  
Root, James H., Jr., Waterbury

#### HARTFORD COUNTY

Burness, Sidney H., Hartford  
Calverley, Eleanor T., Hartford  
Connors, George M., Plantsville  
Moriarty, Mortimer E., Manchester

## THE HARTFORD COMMUNITY CANCER CONSULTATION CLINIC

*The following description of the operation of the Hartford Clinic was made available for publication at the request of the JOURNAL.*

THE Community Cancer Consultation Clinic developed in Hartford is an experimental pilot project sponsored jointly by the Connecticut Cancer Society and the Association of State Tumor Clinics. Its object is to give personal professional advice regarding malignant disease to any person living in the environs of Hartford who may be properly in need of such advice without regard to individual financial status. The Connecticut Cancer Society has assumed the financial responsibility of securing and maintaining the professional, lay and physical facilities necessary to implement the project. The Association of State Tumor Clinics through its Executive Committee has assumed responsibility for the competence and integrity of the professional personnel. In order to select a properly balanced group of specialists, the Tumor Committees of each of the four hospitals in Hartford were asked by the President of the Hartford Branch of the Connecticut Cancer Society to nominate one or more physicians who might constitute a Community Executive Committee, the relative numerical representation of each hospital Tumor Committee on the Community Executive Committee having been predetermined by the Executive Committee of the Association of State Tumor Clinics.

This Community Executive Committee (1) appoints the physicians who comprise the Community Cancer Consultation Clinic subject to the approval of the Executive Committee of the Association of State Tumor Clinics; (2) evaluates the records, follow-up, and general operation of the project from a professional point of view in conjunction with the workers, officers and Executive Committee of the Hartford Branch of the Connecticut Cancer Society; and (3) is in a position to discuss the objectives and operation of the Clinic with physicians, public health nurses, social service workers or other properly interested groups.

The personnel of the Community Cancer Consultation Clinic comprises five physicians; two internists, a surgeon, a gynecologist and a urologist.

Each physician is a trained specialist, either a diplomate of a Specialty Board or actively preparing to take a Specialty Board examination. All have evinced an interest in cancer and are active members of the staffs of their respective hospitals.

Beginning on January 28, 1947, this Community Cancer Consultation Clinic met regularly and promptly at nine o'clock every Tuesday morning at the McCook Memorial Hospital. This is a municipal hospital supported by public funds and its excellent facilities have been made available to the Community Cancer Consultation Clinic through the intelligent and generous action of the Welfare Board of the City of Hartford for a nominal fee for each session. Patients are seen by the Clinic by appointment only. The Executive Secretary of the Hartford Branch of the Connecticut Cancer Society makes the appointment either by telephone or individual visit at the central downtown office of the Society. The telephone is listed under Connecticut Cancer Society (2-4864).

The Clinic meets in the Out-patient Department and, as there is no other clinic meeting at this particular hour, adequate facilities of every description are available. There is waiting space, the Executive Secretary of the Hartford Branch of the Connecticut Cancer Society is there to check the patients with the appointments which she has previously made, a stenographer takes the identification data and the notes as dictated by the Clinic physicians at the conclusion of their various examinations. There are five completely equipped examining rooms and sufficient nursing personnel so that each physician may spend as long securing the history, examining the patient and calling on his confreres for consultation in the individual case as may be indicated—all with dispatch but without haste. Except for confirmation of the appointment and necessary identification data patients are seen by the physician first. It is the intention of the Clinic that each patient shall be seen and examined in private by the physician before any inquiry into financial status or other social factors is made, precisely as though the patient had come into that particular physician's private office. In order to promote this personal and confidential relationship between the patient and the physician, each of the highly trained specialists



in the Clinic becomes for the time being a family physician of the ideal type and, insofar as it may seem desirable to him, the patient's personal and social history is gone into in adequate detail. The physical examination is carefully and completely done and such consultation with the other specialists comprising the Clinic as may be indicated is secured. The laboratory and clinical data are then correlated, the patient given such advice as is ethically and medically proper and the positive findings and disposition of the case are indicated. In the course of the visit each patient has a routine urinalysis, hematocrit, blood smear, Mazzini flocculation test, x-ray examination of the chest, Papanicolaou smear in the case of females and such other laboratory work as may seem indicated by the examining physician. Dr. Hough, the director of the hospital laboratory, is immediately available for conference and thus constitutes the sixth member of the Clinic and represents the specialty of pathology, an essential specialty in every type of group medical practice. The first five items in the laboratory routine are completed by the regular trained technical staff of the McCook Memorial Hospital before the patient is dismissed from the clinic and the findings, therefore, are available to the clinical group. Furthermore, it is possible to do biopsies and to secure frozen sections at any time, if this is indicated. There are excellent x-ray facilities available at McCook Memorial Hospital and, if the patient is considered to be in the medically indigent class after inquiry by the Executive Secretary of the Cancer Society, her simple statement to that effect is accepted by the Welfare Board of the City and any x-ray examinations that may be indicated are secured either at the cost of the material or absolutely free as the circumstances demand.

As the primary object of the Clinic is to be of service to the physicians in the Community, particularly in the case of patients who may be in the medically indigent economic group, a request from any physician in the Community that a patient should be seen at the Clinic is invariably accepted at once without further discussion and such a patient may be assured of an appointment on the following Tuesday morning. If a patient is referred by a physician in the Community, the history, positive physical findings and laboratory data together with any suggestions for further investigation or treatment are forwarded to the referring

physician by mail over the signature of the Chairman of the Clinic group. At the end of a week the Executive Secretary of the Cancer Society contacts the referring physician by telephone to be sure that the patient did return to the referring physician and offers any further help that the clinic may be able to give in the way of diagnosis or follow-up.

Patients referred by Social Agencies have second call on the facilities of the Clinic. If, after being seen in the Clinic and the patient's economic status confirmed by the Executive Secretary of the Cancer Society, such patients as should properly afford it are directed into the care of physicians of their choice and the data is forwarded to that physician precisely as though he had personally referred the patient to the clinic, the Social Agency simply being informed of the disposition of the case. If the patient has no physician of choice or, after investigation, appears to the Executive Secretary of the Cancer Society to fall into the semi-private or private classification, the Executive Secretary secures the names of three physicians from the Information Bureau conducted by the Hartford Medical Society, the patient selects one of these and the previously described routine is followed out. If, on the other hand, investigation shows that the patient is in an economic group which, in the opinion of the Executive Secretary of the Cancer Society, cannot afford a private physician, the patient is referred to the Cancer Clinic at one of the local hospitals if there is reason to believe that there is malignant disease. If there are conditions which make further investigations or treatment necessary or desirable but which are not believed to be malignant disease, the patient is referred to the diagnostic clinic in one of the local hospitals, to the municipal clinic in the McCook Hospital, to the Hartford Dispensary, to the ward service of one of the hospitals in the Community or to such other Agency as the Clinic physician may direct the Executive Secretary. The responsibility for the disposition of the patient is invariably assumed by the Clinic physician, never by the Executive Secretary who simply implements the decisions of the professional staff.

Individuals not referred by physicians or Social Agencies are also seen in the Clinic by appointment. These individuals are questioned by the Executive Secretary when they telephone for an appointment and, insofar as possible, seen by her in the downtown office of the Society before being

given an appointment to be seen in the Clinic. A very specific effort is made after the social investigation by the Executive Secretary to siphon such individuals into proper channels. Those who merely want a routine physical examination and are financially able to pay a proper fee are directed to their own physician or, if they have no family physician, to one selected by them from the list submitted by the Information Bureau of the Hartford Medical Society. Since there is by no means an inconsiderable number who have been concerned about themselves because of the widely diffused program of cancer propaganda, this group too, insofar as possible, is siphoned into the hands of physicians who are able and willing to satisfy the demands of this group. Others so obviously need the help and advice of various Social Agencies that it is not always necessary to refer them to physicians or organized medical groups. However, everyone who applies and is directed elsewhere than to the Clinic is followed up and every effort is made by the competent and sympathetic Executive Secretary to further the objectives of the American Cancer Society and the Connecticut Cancer Society in particular. That group, however, which for one reason or another should be seen by the Cancer Consultation Clinic is invariably cared for, as it is the desire of everyone connected with the project to be of service to the individual, the physician and the community.

It is obvious that the statistical results insofar as the discovery of malignant disease is concerned in such a Clinic is determined by the degree of screening to which the patients seen are subjected prior to their being examined at the Community Consultation Clinic. To the date of this interim report 296 individuals have passed through the Clinic. Of these 35 were referred by 25 different physicians. 14 were referred by five different Social Agencies and 247 from the downtown office of the Hartford Branch of the Connecticut Cancer Society. One cancer of the breast, one cancer of the esophagus, nine cancers of the skin and one sarcoïd of the rectum have been seen. Two of these patients received no therapy; one a very old man and one a patient at the County Jail for whom it has not been as yet possible to complete plans. Twenty-two appointments were broken.

The five physicians devoting themselves to the Clinic were each paid \$25 per session, a total of \$2,825. The McCook Memorial Hospital was paid \$20 per session for the use of the space and the

laboratory examinations were paid for at cost, a total of \$731.01. Equipment and office supplies have amounted to \$283.44 and miscellaneous expenses have been \$40. The total costs for operating the Clinic to the time of this report has, therefore, amounted to \$3,879.45 or \$13.11 for each patient seen or \$323.29 for every cancer patient seen by the Clinic group and given advice, or, as probably only one of the malignant tumors found was unsuspected before the patient was examined, \$3,879.45 for discovering one case of cancer.

No effort has been made by the Hartford Branch of the Connecticut Cancer Society to recover from any individuals presenting themselves at the Cancer Consultation Clinic any part of the cost of the operation of the Clinic.

### State Society President Speaks in Louisville

James R. Miller, president of the Connecticut State Medical Society, addressed the Louisville (Kentucky) Cancer Symposium on August 29 as one of the after dinner speakers. Dr. Miller discussed "The Role of the American Cancer Society." At special ceremonies during the symposium conducted by the Kentucky Division, American Cancer Society, in cooperation with the Kentucky State Medical Association, the State Department of Health, and St. Joseph Infirmary, Louisville, the first cancer detection mobile unit was dedicated in that state. It is anticipated that this new mobile unit will be of inestimable value to members of the medical profession in Kentucky who desire assistance in cancer detection, diagnosis and treatment.

### Dr. Burlingame Honored by French

C. Charles Burlingame, psychiatrist-in-chief of the Institute of Living, has received another signal honor, this time from the French Government in the form of elevation from Knight of the French Legion of Honor to the rank of Officer of the Legion. Dr. Justin Godart was commissioned by the French Government to decorate Dr. Burlingame. Official notification was given at a banquet in New York City on September 10. Dr. Burlingame now holds, in addition to this decoration of the French Legion of Honor, the French Medal of Honor in Gold, the French Academy Order of the University of Palms, and the officer's grade of St. George and Notre Dam de Mont Carmel.



## Manchester's Grand Old Man Passes On



D. C. Y. MOORE, M.D.

To have continued the active practice of medicine up to the age of seventy-eight in spite of an attack of coronary occlusion a few years ago is to have achieved where many another of a less hardy constitution has failed. Add to that the fact that from April 1945 to April 1947 Dr. Moore served as councilor for the Hartford County Medical Association in the State Society, that he was still chairman of the Manchester Board of Health as well as medical examiner at the time of his death, that he was active in the Manchester Kiwanis Club of which he was a founder, and in the Manchester Chamber of Commerce of which he was a past president, and one begins to realize what a large part Dr. D. C. Y. Moore occupied in the life of his city. He was indeed Manchester's "Grand Old Man."

Twice president of the Hartford County Medical Association, one of the founders and a former president of the Manchester Medical Society, a founder of the Manchester Memorial Hospital and one of the first presidents of the Connecticut Public Health Association, Dr. Moore's career has been outstanding as a leader in both civic and medical affairs. A kindly gentleman who started practice

on a bicycle before the days of street lights, his mental alertness kept him abreast of the times and made his counsel much sought and highly respected.

Connecticut Medicine has lost one of its beloved and venerated leaders. The memory of his hearty handshake will long remain with us.

## Announcement of the Connecticut Postgraduate Seminar of Neuropsychiatry

(September 29, 1947—April 26, 1948)

Sponsored by Joint Committee of the State Mental Hospitals and Department of Psychiatry and Mental Hygiene, Yale University School of Medicine.

### EXECUTIVE COMMITTEE

Edgar C. Yerbury, M.D., Superintendent (chairman), Connecticut State Hospital, Middletown, Connecticut.

Philip J. Moorad, M.D., New Britain, Connecticut (representative of the Connecticut State Medical Society).

Frederick C. Redlich, M.D., Department of Psychiatry, Yale University School of Medicine, New Haven, Connecticut.

Clements C. Fry, M.D., Department of University Health, Yale University, New Haven, Connecticut.

Paul I. Yakovlev, M.D., director of Research and Training, Connecticut State Hospital, Middletown, Connecticut (Curricular Secretary of the Seminar).

The Seminar is intended to meet the needs of the physicians of the psychiatric hospitals; of the house officers, residents and interns of psychiatric and general community and private hospitals; of the members of medical staffs and residents in training of the neuropsychiatric services of the Veterans Administration Hospitals, and of the interested private practitioners. The Seminar will begin Monday, September 29, 1947 at 2:00 P. M., at the Connecticut State Hospital, Middletown.

The program of the Seminar will consist of 93 two-hour lectures and demonstrations from September 29, 1947 to April 26, 1948. These will be held one a week, each Monday, from 2:00 to 4:00 P. M., 5:00 to 7:00 P. M., and 8:00 to 10:00 P. M. In addition sessions will be held on Wednesday, December 10, 1947, March 24, 1948, and April 21, 1948, at the same hours. There will be recess from December 11, 1947 to January 5, 1948.

All sessions of the Seminar from September 29, 1947 to and including January 26, 1948 will be held at the Connecticut State Hospital in Middletown. All sessions from February 2, 1948 to and including April 26, 1948 will be held at the Department of Psychiatry, Yale University School of Medicine, Room 305, 333 Cedar Street, New Haven, Connecticut.

The curriculum of the Seminar will consist of review and orientation lectures in subjects specially relevant to the study and practice of neuropsychiatry. The entire program will consist of the following five consecutive periods:

1. REVIEW OF BASIC DISCIPLINES OF NEUROLOGY AND RELATED SUBJECTS

Thirty-six lectures including practical exercises in anatomy, microscopy, and in the reading of EEG records and of x-ray plates; Mondays, from September 29 through and including Wednesday, December 10, 1947.

	LECTURES
Neuroanatomy .....	9
Physiology .....	6
Neuropathology .....	7
Endocrinology .....	6
Electroencephalography .....	4
Roentgenography .....	4

2. REVIEW OF TOPICS OF CLINICAL NEUROLOGY APPLIED TO PSYCHIATRIC PRACTICE

Twelve lectures; Mondays from January 5 through and including January 29, 1948.

3. CLINICAL AND SOCIAL PSYCHIATRY, APPLIED PSYCHOLOGY AND SOCIOLOGY

Twenty-seven lectures; Mondays from February 2 through and including Wednesday, March 24, 1948.

	LECTURES
General psychopathology .....	6
Clinical and experimental psychology.....	5
Social anthropology applied to psychiatry	1
Social psychiatry .....	5
Clinical and hospital psychiatry.....	7
Forensic psychiatry .....	2
Psychiatric education and training.....	1

4. REVIEW OF THERAPY IN PSYCHIATRY

Nine lectures; Mondays from March 29 through and including Wednesday, March 24, and Mondays, April 5 and 12, 1948.

	LECTURES
Psychotherapy .....	5

Group and occupational psychotherapy.....	1
Shock therapies .....	2
Lobotomy .....	1

5. REVIEW OF PEDIATRIC NEUROPSYCHIATRY (CHILD PSYCHIATRY)

Nine lectures; Mondays from April 19 through and including Wednesday, April 21, and Monday April 26, 1948.

	LECTURES
Developmental diagnosis of infant behavior	1
Development of social behavior.....	1
Behavior disorders and neuroses in children	1
Psychoses in children.....	1
Psychotherapy with children.....	1
Child guidance and mental hygiene in adolescence .....	1
Mental hygiene in adolescence and college age .....	1
Scholastic disabilities in children and their remedial training .....	1
Mental deficiency .....	1

The time schedule of the lectures, with the names of the lecturers, will be released in the near future.

The registration for the Seminar is \$1. The Seminar fee is \$25. Interns, house officers, and residents in training in the State hospitals, Veterans Administration and community and private hospitals are required to pay only the registration fee. The Seminar fee for all other physicians may be waived by the executive committee on application by the registrant.

Those interested in attending the Seminar are requested to write to Dr. Paul I. Yakovlev, Curricular Secretary of the Seminar, Department of Psychiatry, Yale University School of Medicine, Room 328, 333 Cedar Street, New Haven 11, Connecticut. Letters of application must be accompanied by registration fee, payable to Yale University. The Seminar fee will be payable September 29, 1948 and will be applied solely to defray the expenses of the Seminar. The applicants should indicate their professional status (resident, intern, State hospital physician, private practitioner, etc.) and the mailing address. The number of accepted applicants will be determined by the class facilities available.

It is assumed that interns, house officers, residents in training and physicians on full time staff of hospitals will obtain, prior to registration, the approval of their medical or administrative authorities to attend the Seminar regularly.



Professional workers in neuropsychiatry and related fields, psychologists, psychiatric social workers and nurses may attend lecture in which they may be interested by individual permission of the curricular secretary.

Paul I. Yakovlev, M.D., Curricular Secretary

#### LECTURERS

Raymond D. Adams, Selden D. Bacon, Donald H. Barron, Joseph Beauchemin, Francis G. Blake, Charles Bradley, John R. Brobeck, Charles C. Burlingame, Harold S. Burr, Louis H. Cohen, James M. Cunningham, William D. Curtis, Neil A. Dayton, Derek Denny-Brown, John Dollard, Louise Eisenhardt, Emerick Friedman, Samuel Friedman, James C. Fox, Jr., Clements C. Fry, John F. Fulton, Arnold Gesell, Helen R. Gilmore, William F. Green, Riley H. Guthrie, Jules Holzberg, Carl I. Hovland, Robert Knight, Lawrence S. Kubie, Harold D. Laswell, Margaret A. Lennox, William G. Lennox, Averill A. Liebow, Robert D. Livingston, Cyril N. H. Long, H. Houston Merritt, Neil E. Miller, Burness E. Moore, Richard Newman, John R. Paul, Everett S. Rademacher, Frederick C. Redlich, Arthur H. Ruggles, Jane A. Russell, William T. Salter, Seymour B. Sarason, Benjamin Simon, Theodore P. Sohlner, George S. Stevenson, Alfred E. Wilhelmi, Hugh M. Wilson, David G. Wright, Paul I. Yakovlev, Herman Yannet, Edgar C. Yerbury.

### Dr. Haggard to Broadcast on AMA Program

Howard W. Haggard, M.D., director of the laboratory of applied physiology at Yale University, is one of the discussants in a new series of radio interviews recently prepared by the American Medical Association. The series is entitled "The Story of Surgery," and the interview with Dr. Haggard tells of the progress of surgical techniques since the middle ages.

### Joins AMA Committee

Dr. John S. Lockwood, Columbia University College of Physicians and Surgeons, New York, has accepted membership on the Therapeutic Trials Committee of the A.M.A. Dr. Lockwood continues to maintain his membership in the Connecticut State Medical Society.

### Growth of Prepayment Plans

Six million plus as the June 30, 1947 enrolment in medical society sponsored prepayment plans is based on returns to date and a conservative estimate of plans not yet reporting. Actually when all returns are tabulated it may reach the six and a quarter million mark. In any event the rate of growth,

approximately 200,000 per month, is encouraging.

The average over-all percentage enrolment increase for this six months period amounted to 31 per cent.

### White and Geschickter's Diagnosis Released by Lippincott

The J. B. Lippincott Company of Philadelphia has just released "Diagnosis in Daily Practice," a guide to office study by Benjamin V. White of Hartford and Charles F. Geschickter of Washington, D. C.

The book bridges the gap between the elaborate diagnostic procedures taught by leading medical schools and the overly abbreviated technics so often forced upon busy practitioners. The presentation starts with the thesis that the great bulk of deaths and disability in the United States is caused by a comparatively small number of diseases. The early manifestations of these diseases constitute a frame work around which a routine health survey is constructed. The health survey is composed of a small number of historical questions, physical findings and laboratory tests which are adequate for the recognition or exclusion of the statistically important entities.

The major portion of the text is devoted to the elicitation and pathologic physiology of the clinical and laboratory abnormalities to be sought on examination and to their diagnostic significance for both common and rare diseases. The final chapters are composed of "thumb-nail" sketches of the major entities and tables on their differentiation.

The book was primarily evolved for physicians in medical practice and is built around a printed history and physical examination form which is keyed to the chapters in which the abnormalities are discussed. However, a "medico-legal" form is also included to show how the basic examination can also be employed in industrial, military and insurance work. The placing of emphasis on the complaints and abnormal findings which point to the major fatal and disabling disorders makes it possible for the physician to free his mind from inconsequential details and to conduct a thorough examination in a reasonable length of time.

Dr. White is assistant visiting physician and chief of the gastroenterologic clinic at the Hartford Hospital. He is also associated with the Veterans Administration as branch section chief in gastro-

enterology for New England and as consultant in gastroenterology at Newington. He is assistant clinical professor of medicine at Yale and consultant in gastroenterology at the Institute of Living.

Dr. Geschickter is professor of pathology at Georgetown University, consultant in pathology at the Mt. Alto Veterans Hospital, pathologist in chief at the Gallinger Municipal Hospital and Georgetown University Hospital, all in Washington, D. C. He is also consulting pathologist at the U. S. Naval Medical School in Bethesda, Maryland.

### Dr. Tovell to Command Reserve Unit

Appointment of Colonel Ralph M. Tovell, Medical Department, Organized Reserve Corps, to command the 125th OR Composite Group has been announced by the office of Colonel Ira W. Black, Senior State Instructor ORC for Connecticut.

The 125th Composite Group is composed of reserve officers and enlisted reservists of the Medical Department Reserve of the Army and includes members of the Dental Corps, Pharmacy Corps and Veterinarians; as well as Medical Administrative personnel; Army Nurses and Women Medical Specialists including psycho-therapists and dietitians. Sections of the group are located in Hartford, New Haven and Bridgeport.

Colonel Tovell, who was recently commissioned in the Organized Reserve Corps, was first brought into the Army Medical Department in August, 1942, when he was appointed lieutenant colonel and sent to England where he served as senior consultant in anesthesia on the staff of the chief surgeon of the European Theater of Operations and received his promotion to colonel. He remained in this capacity until his return to the United States in July, 1945.

While in England, Colonel Tovell was made an Honorary Fellow in the Association of Anesthetists of Great Britain and Ireland in recognition of his outstanding work in this field of medical science.

Upon return to this country, he was assigned to duty in the office of the surgeon general, U. S. Army in Washington, where he continued to serve as consultant in anesthesia until he was relieved from active duty in October 1945.

Dr. Tovell is director of anesthesiology at the Hartford Hospital and is active in numerous medical and scientific societies including the American Board of Anesthesiology, the American College of

Surgeons, and the American Medical Association. He is consultant to a number of hospitals in this vicinity, and the Veterans' Administration in Washington.

In assuming his new command, he is personally directing the initial planning for the fall and winter inactive training program of medical reserve personnel assigned to his group in the Hartford, New Haven and Bridgeport areas, and has recently completed the assignment of staff officers and subgroup commanders who will function with him in the various phases of his unit's activities in military medicine.

### Dr. Miller Appointed to A.M.A. Scientific Exhibit Committee

Plans have been completed for the Scientific Exhibit to be held at the midwinter session of the American Medical Association in Cleveland, January 5 to 8. Exhibitors who have material of particular interest to the physician in general practice will be invited to participate.

The meeting on January 5 and 6 will be devoted to industrial health, and the scientific exhibits will be arranged with special emphasis in this field. Other subjects to be emphasized are cancer, heart disease, first aid in motor accidents, diabetes, hearing aids, dermatology in general practice, endocrine diseases and nutrition. There will be question and answer conference rooms for the benefit of physicians seeking specific information, and motion pictures will be shown continuously throughout the week.

Dr. Dwight H. Murray, Napa, Calif., has been appointed Chairman of the Committee on Scientific Exhibit in place of the Dr. Louis H. Bauer, Hempstead, N. Y., who has been appointed to the Executive Committee of the Board of Trustees. The other two members of the Committee on Scientific Exhibit are Dr. James R. Miller, Hartford, Conn., and Dr. E. J. McCormick, Toledo, Ohio.

### Blue Cross to Have Public Relations Director

General Manager Robert Parnall of Connecticut Blue Cross has announced the appointment of Theodore Wachs, Jr., as Director of Public Relations for the non profit hospital plan.

Mr. Wachs comes to Connecticut from Chattanooga, Tennessee, where, during the past year and



half, he helped organize and operate the Tennessee Hospital Service Association, one of the newest of the 87 nationwide Blue Cross Plans. Before entering Blue Cross work, Mr. Wachs was for five years Special Agent of the Federal Bureau of Investigation, serving the FBI offices at New York, Miami, Chattanooga, and Baltimore. A graduate of Dartmouth College, he was formerly in the advertising department of Conde Nast Publications at New York City and Greenwich, Connecticut, and did promotional work for trade magazines in Chicago.

As Connecticut Blue Cross enters its second decade of public service, Mr. Wachs' assignment will be to highlight the Plan's hospital care program and keep the 688,000 Connecticut members informed of Plan achievements and problems.

### **New Resident in Psychiatry at Middletown**

Dr. Betty-Jane Anderson of Guilford has been appointed to a year's residency in psychiatry on the staff of the Connecticut State Hospital, Middletown, according to a recent announcement by Dr. Charles Russman, assistant superintendent.

A graduate of Skidmore College in 1944, Dr. Anderson received her medical degree at Tufts College Medical School in 1946, and recently completed her internship at Bridgeport Hospital. She is the daughter of Dr. and Mrs. C. Franklin Anderson, also of Guilford.

### **Dr. Charles L. Wilson on AMA School Health Conference Program**

The Bureau of Health Education of the AMA is conducting a Conference on the Cooperation of the Physician in the School Health and Physical Education Program at Highland Park, Illinois, October 16, 17 and 18. Charles L. Wilson, M.D., of New Haven is chairman of the Section on School Health Service Problems.

### **Filipino Physicians Visit New Haven**

Two Filipino physicians, Conrado Pascual and Trinidad Gomez, employed in the Manila office of the U. S. Public Health Service, recently visited New Haven and made a study of health methods and administration, with particular emphasis on maternal and child care.

They represent the vanguard of 25 Filipino doc-

tors employed in the Philippine government and in Federal agencies in Manila, who have been named fellows of the U. S. Public Health Service under the provisions of the Philippine Rehabilitation Act of 1946.

Of the 25 fellows, 11 either have arrived in the States or are enroute to take up postgraduate courses for a year in various American universities, particularly in the East. Dr. Gomez is one of the five women among the first group of 11 Filipino fellows, and is the first of the group to arrive with Dr. Pascual in the States.

The Filipinos were particularly impressed with the close cooperation between the City Department of Public Health and the civic agencies. With such a setup, Dr. Pascual said excitedly, "One wonders how a child can die in this city!"

### **Appointed Chairman of State Tuberculosis Commission**



JOSEPH I. LINDE, M.D.

Dr. Joseph I. Linde, health officer for the City of New Haven, was recently appointed chairman of the Connecticut State Tuberculosis Commission by Governor James L. McConaughy.

A member of the commission since 1939 when his appointment was recommended by the State Medical Society, Dr. Linde is also a member of the Building Program Committee for the state's humane

and welfare institutions created at the last session of the General Assembly. He is a Fellow of the American Public Health Association, and a member of the Connecticut Public Health Association and the Society's Committee on Public Health.

Other members of the Tuberculosis Commission are Marion Douglas, R.N., executive director of the Hartford Visiting Nurse Association; Herbert M. Lerou of Norwich; Ellwood Stanley, Trumbull; and John T. Walsh, Ansonia.

### General Hospitals Treating Mental Patients

Opinion addressed to the Public Welfare Council dated July 25, 1947:

Hon. Raymond J. Cannon, Assistant Attorney General.

In your letter of July 18, 1947 you ask our opinion as to whether a general hospital becomes a hospital for mental illness when the general hospital establishes facilities to treat patients for psychoses within the meaning of Section 1762 of the General Statutes, Revision of 1930 a. a. by Secs. 249f and 252f of the 1941 Supplement and whether such general hospitals should be required to make quarterly reports concerning patients treated for psychoses at such general hospitals.

Section 1762 of the General Statutes as amended is as follows:

"All hospitals for mental illness in this state shall be subject to the inspection and visitation of the Public Welfare Council, and shall be so visited and inspected at least once in six months in each year. Each keeper of a hospital for mental illness in this state shall, quarterly, make written return to said Public Welfare Council, stating the name, age and sex of each patient confined therein and the time when committed and by whom, which return shall contain such other information and be in such form as the Public Welfare Council may prescribe."

It is apparent that this statute imposes two separate and distinct duties upon the Public Welfare Council, both of which, however, are somewhat closely allied considering the ultimate aim of the State in carrying out its obligation to society in general and to mentally ill persons in particular. The first duty imposed requires that the Council visit and inspect all hospitals for mental illness at least once in six months of each year. Secondly, the Public Welfare Council is required to obtain from each such hospital quarterly reports containing certain

specified statistical information about each patient and such other data as the Public Welfare Council may prescribe.

The public health and general welfare demands that the State exercise some supervision over all institutions, detaining or confining persons afflicted with mental illnesses. In other than State hospitals, this supervision pertains particularly to the conditions under which such persons are confined, more specifically to insist upon intelligent and humane treatment and to require such institutions to maintain reasonable standards of health, safety and sanitation.

Another phase of the State's obligation in this field is to provide suitable hospital facilities for the care and treatment of mentally ill persons, particularly for those who, because of finances or other reasons, are unable to obtain adequate hospitalization elsewhere. In the interests of the general health and public welfare, the State is continually expanding its activities in caring for and treating these unfortunate people. In order to properly carry out its full duty and to plan, establish and maintain adequate hospital facilities for the care and treatment of mentally ill persons, it is necessary for the State to have full and complete statistical information concerning all persons who are detained or confined because of such illnesses.

It is therefore our opinion that Section 1762 of the General Statutes as amended by Sections 249f and 252f of the 1941 Supplement does apply to general hospitals when such hospitals establish facilities for the treatment and detention of patients suffering mental illnesses. We feel that the generally accepted concept of the State's duty in regard to mentally ill persons necessitates such an interpretation.

### New Haven Rheumatic Fever and Cardiac Program

The New Haven City Health Department has established the New Haven Rheumatic Fever and Cardiac Program for children and young people up to twenty-one years of age, in cooperation with the Connecticut State Department of Health and the Department of Pediatrics, Yale University School of Medicine.

In his recent announcement of the program, Dr. Joseph I. Linde, New Haven's health officer, said that Dr. Ruth Whittemore, assistant clinical pro-



fessor of medicine at Yale University School of Medicine, and assistant attending physician at New Haven Hospital, has been selected to direct the program.

The plan calls for the immediate organization of a diagnostic clinic, to be located in the pediatrics department of the Grace-New Haven Community Hospital. In addition, the program will offer an advisory service for the future care of children stricken by the disease.

The program places New Haven among the first cities in the nation to recognize the treatment of rheumatic fever as a problem in public health. Plans to establish similar programs are now under consideration in approximately twenty states.

A graduate of Johns Hopkins University School of Medicine and Mount Holyoke College, Dr. Whittemore was an intern and assistant resident physician in pediatrics under Dr. Grover V. Powers at the Yale University School of Medicine, and has been a fellow in pediatrics at the Massachusetts General Hospital. She was formerly assistant resident in pediatrics at the Harriet Lane Home, Johns Hopkins Hospital, and assistant instructor in pediatrics and assistant physician for the Harriet Lane Cardiac Clinic under Dr. Helen B. Taussig from 1945 to 1947.

### Winston-Salem Physician Is Named to A.M.A. Board of Trustees

The Board of Trustees of the American Medical Association has appointed Dr. Wingate M. Johnson, professor of clinical medicine at the Bowman Gray School of Medicine of Wake Forest College, Winston-Salem, N. C., to fill the unexpired term of the late Dr. Charles W. Roberts on the Board of Trustees.

Dr. Roberts, who was 63, passed away in Atlanta last July 28. He was first elected to the Board of Trustees in 1941 and 1946 he was reelected for a second term of five years.

The A.M.A. Board of Trustees is composed of nine physicians and carries out the policies adopted by the House of Delegates, conducts the business affairs of the Association and has general supervision of the work of the various councils and bureaus. Dr. E. L. Henderson, Louisville, Ky., is chairman of the Board.

Dr. Johnson, who is 62, graduated from Jefferson Medical College, Philadelphia, in 1908 and has practiced in Winston-Salem for many years. He is past

president of the North Carolina State Medical Association and author of many medical monographs and papers. He is widely known in the field of internal medicine. He also served as president of the American Geriatrics Society.

### Admiral McIntire Director of Blood Program

Vice Admiral Ross T. McIntire, wartime Surgeon General of the U. S. Navy, and formerly White House physician, has been named director of the new National Blood Program of the American Red Cross.

Dr. McIntire will have supervision of the most far-reaching health program in the peacetime history of the Red Cross, Mr. O'Connor, the organization's president, said. It is being undertaken, he pointed out, in direct response to the urgent need of the medical profession for blood in saving of life as well as in treatment and prevention of disease.

At the program's peak an estimated 3,700,000 blood donations will be required annually. Mr. O'Connor said this would necessitate establishment of strategically located centers where procurement of blood can be carried on under scientifically controlled conditions.

### New Zealand Compulsory Health Insurance

*Insurance Economic Surveys* reports that the New Zealand compulsory health insurance program has gone wrong somewhere. For the past eight years costs have been continually rising. Overworked physicians find their offices crowded with persons whose complaints are often trivial and sometimes quite imaginary. The expenditure on drugs, which approaches that for medical consultations and treatment, has been the subject of much comment. Sheer waste apparently is at the bottom of this difficulty. Under the prevailing plan now operating the patient visits any physician he pleases, pays him 10s. 6d., which always has been the standard fee for a consultation, and receives a receipt which entitles him to collect 7s. 6d. from the State.

The medical profession now proposes a revision of the scheme to lighten the cost, but with a continuance of maternity benefits and other expensive items. They also propose that each citizen should pay directly for treatment for minor ailments, unless he is genuinely unable to do so. The medical profession believes this change would clear away the trivial cases which constitute the bulk of the physicians' work at present.

## TRUST IS THE CORNERSTONE

People everywhere live and prosper by trusting each other. All business and the nation's money is based on "I Promise to Pay . . ."

There are moral promises, too . . . the promise of every responsible person to do his best, the promise of the employer to look after his employees, the promise of the statesman to protect the interests of our people. Above all, the promise of the physician to heal the sick.

These are promises of human relationships. Their fulfillment extends our faith in civilization.

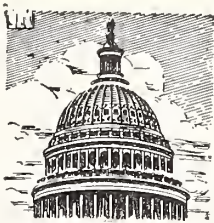
Confidence is the Basis  
of Good Public Relations





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PUBLIC  
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NEWS FROM WASHINGTON

Status of Health Legislation, 80th Congress

BILLS ENACTED INTO LAW

S591—To amend the act of incorporation of the American Red Cross. Approved May 8, 1947. Public Law No. 10.

S1661—Army, Navy and Public Health Service Medical Officer Procurement. Approved August 5, 1947. Public Law No. 365.

HR775—Commission on the Reorganization of the Executive Department. Approved July 7, 1947. Public Law No. 162.

HR1943—Army and Navy Nurse Corps. Approved April 16, 1947. Public Law No. 36.

HR2045—Amend the Federal Food, Drug and Cosmetic Act (Streptomycin). Approved March 10, 1947. Public Law No. 165.

HR2700—Labor and Federal Security Appropriation Act. Approved July 8, 1947. Public Law No. 165.

HR3215—Army and Navy Medical Service Corps. Approved August 4, 1947. Public Law 337.

HJRes. 167—Recognize uncompensated services rendered under Selective Service Training Act. Approved June 30, 1947. Public Law. No. 130.

BILLS PASSED BY BOTH HOUSES BUT VETOED BY

PRESIDENT

S526—National Science Foundation. Pocket Vetoed August 6, 1947.

STATUS OF SENATE BILLS

S140—Department of Health, Education and Security. Reported in the Senate Amended June 6, 1947. Senate Report No. 242.

S164—Commission on the Reorganization of the

Executive Department. HR775 passed in lieu thereof June 27, 1947.

S545—Taft Health Bill. Hearings recessed July 23, 1947 and will resume again in January.

S712—Department of Health, Education and Security. Committee reported S140 amended in lieu thereof June 6, 1947. Senate Report No. 242.

S1143—Provide for the procurement of physicians and surgeons for the Army. Abandoned in Committee and reported S1661 amended in lieu thereof. Senate Report No. 608.

S1197—Provide for the procurement of physicians and surgeons for the Navy. Committee reported S1661 amended in lieu thereof. Senate Report No. 688.

S1320—Wagner-Murray-Dingell bill. Hearings recessed July 23, 1947, and will resume in January.

S1454—Amend the Public Health Service Act (Grants for postgraduate schools in Public Health). Reported in the Senate July 7, 1947. Senate Report No. 437.

SJ Res. 98—World Health Organization. Passed the Senate July 7, 1947. Referred to the House Committee on Foreign Affairs.

NEW BILLS INTRODUCED IN THE SENATE BEFORE

RECESSING

S1649—by Mr. Saltonstall of Massachusetts, July 17. A bill to authorize the *payment of certain claims for medical care* and treatment of personnel of the Army, Navy, Marine Corps, Coast Guard, Coast and Geodetic Survey, and Public Health Service furnished other than by activities of the Federal Government; and for other purposes. Referred to the Committee on Armed Services.

*Comment:* Companion bill to HR3540.

S1661—by Mr. Morse of Oregon, July 18. A bill to provide additional *inducements to physicians, surgeons, and dentists* to make a career of the United States military, naval and public health services; and for other purposes. Referred to the Committee on Armed Services.

*Comment:* This is a *committee bill* prepared after considering several bills recommended by the Army and Navy; S1511 and HR3851 favorably reported by the House Armed Services Committee. The bill provides that commissioned medical and dental officers of the Army, Navy and Public Health Service shall be given extra pay at a rate of \$100 per month in addition to their base and longevity pay. Permission is granted the President by and with the consent of the Senate to make appointments to permanent commissioned grades not above that of Colonel in the Medical Corps of the Army, and Captain in the Medical and Dental Corps of the Navy. The purpose of this bill is to alleviate the shortage of physicians, surgeons and dentists of the respective services.

S1679—by Mr. Murray of Montana, July 21. A bill to provide for a *national program of retirement, survivors, and extended disability insurance*. Referred to the Committee on Finance.

*Comment:* Extends the coverage of old-age and survivors insurance provisions to the self employed, agricultural workers, servicemen, employees of non profit organizations (except clergymen) and employees of State and local governments. The retirement age for women is reduced from 65 to 60. The amount of permitted *earnings by beneficiaries* is increased from \$15 to \$30. An increase is made in the amount of earnings taken into account in benefit computations (from \$3,000 to \$3,600) and there is to be an increase in the benefits for a retired worker. There is to be established a *National Social Insurance Policy Advisory Council* of 12 men and women appointed by the Federal Security Administrator to make policy recommendations.

S1714—by Mr. Pepper of Florida, July 24. A bill to provide for the general welfare by enabling the several states to make more adequate provision for the *health of mothers and children* and for services to crippled children, and for other purposes. Referred to the Committee on Labor and Public Welfare.

*Comment:* This bill makes permanent the *Emergency Maternal and Infant Care Program*. Authorizes an appropriation of \$20,000,000 for the fiscal

year 1949; \$30,000,000 for the fiscal year 1950 and 1951; and such sums thereafter that Congress may determine necessary for the expansion of grants-in-aid to the states for maternal and child health services. Ten per cent of these annual appropriations is made available for dental services for mothers and children. A further authorization of \$15,000,000 for the fiscal year 1949; \$20,000,000 for the next two years; and thereafter such sums as may be necessary for the care and treatment of crippled children.

Establishes a *Maternal and Child Health Advisory Council* composed of not more than 18 members appointed by the Federal Security Administrator without regard to civil service. At least six shall be appointed from the public, and eight from the medical, dental, and related professions. Two-thirds of the Council shall be selected from panels of names submitted by national professional or other agencies and organizations concerned with medical, dental, nursing, hospital, and other professional services related to maternal and child health and crippled children's services.

An additional authorization of \$5,000,000 is made for the purpose of administration, aiding the financing of studies, demonstrations, investigations, research, and training of personnel for maternal and child health and crippled children's services, and to pay salaries of personnel detailed to State agencies, and authorization is made for the appropriation of such sums after the first year as may be necessary for this function.

S1734—by Mr. Murray of Montana, July 25. A bill to amend the Social Security Act by providing for a *national system of unemployment and temporary disability insurance*. Referred to the Committee on Finance.

*Comment:* Broadens the *unemployment insurance protection* to cover employees in agriculture, domestic service, non profit institutions and small firms. Provides a system of payments of benefits to persons out of work due to sickness or disability; payment of benefits ranging from a minimum weekly benefit of \$5 to a maximum benefit of \$30; payment of benefits for a maximum of 26 weeks, after one week waiting period, except in the case of unemployment insurance, the maximum duration of benefits may be increased to 52 weeks if funds are adequate. It substitutes a single simplified national system of unemployment and disability insurance for the present State-by-State system. It establishes a *National Advisory Unemployment and Tempo-*



rary Disability Insurance Policy Council composed of men and women representing the employers and employees in equal numbers and the public to formulate policies, review administrative operations and to discuss problems relating to the insurance. The program is to be financed by a 3 per cent levy on all salaries up to \$3,000 for the calendar year 1948 and thereafter on all salaries up to \$3,600.

#### STATUS OF HOUSE BILLS

HR3924—Amend the Public Health Service Act. (Personnel and Administration.) Reported in the House July 18, 1947. House Report No. 1002.

HJ Res. 161—World Health Organization. Reported in the House July 17, 1947. House Report No. 979.

#### NEW BILLS INTRODUCED IN THE HOUSE BEFORE RECESSING

HR3934—by Mr. Bulwinkle of North Carolina, June 23. A bill to amend the Public Health Service Act with respect to *venereal disease rapid treatment centers*, and for other purposes. Referred to the Committee on Interstate and Foreign Commerce.

*Comment:* Introduced at the request of the Federal Security Administration which urged the continuation of the Venereal Disease Rapid Treatment Centers which were described as having operated with great success during the emergency. It authorizes the use of funds appropriated for the Public Health Service for the establishment, operation, and maintenance of facilities for the diagnosis, treatment, support and clothing of persons afflicted with VD, including the transportation and subsistence of such persons to and from places of treatment; diagnosis and treatment, including emergency treatment for other illnesses through contracts with physicians and hospitals or other institutions; and reasonable burial expenses.

HR4102—by Mr. Wolverton of New Jersey, July 7. A bill to *promote the progress of science*; advance the national health, prosperity, and welfare; to secure the national defense; and for other purposes. Referred to the Committee on Interstate and Foreign Commerce.

*Comment:* A committee bill reported after extensive hearings on similar legislation. Places special emphasis on *cancer, and poliomyelitis research* and contemplates the expenditure of \$25,000,000 annually. The foundation is to be composed of 24 members appointed by the President.

HR4255—by Mr. Hartley of New Jersey, July 17. A bill to establish a United States Commission for the *Promotion of Physical Fitness* and making an appropriation for such Commission. Referred to the Committee on Education and Labor.

*Comment:* Similar to HR220.

HR4390—by Mr. Dingell of Michigan, July 25. A bill to amend the Social Security Act by providing for a national system of *unemployment* and temporary disability insurance. Referred to the Committee on Ways and Means.

*Comment:* Companion House Bill to S1734.

HR4430—by Mr. Goodwin of Massachusetts, July 26. A bill to provide *hospitalization for members of the Reserve* components of the Army, Navy, Marine Corps, and Coast Guard. Referred to the Committee on Armed Services.

*Comment:* Provides *hospitalization, medical and surgical care* in any Army, Navy, or Marine hospital to members of the reserve components, not on active duty, for treatment for any injury, illness, or disease he has suffered or contracted, under such regulations as the President may prescribe.

HR4436—by Mr. Donohue of Massachusetts, July 26. A bill to establish a *Federal Commission for the Physically Handicapped*, to define its duties, and for other purposes. Referred to the Committee on Education and Labor.

*Comment:* Creates a Commission composed of seven members; the President, and Secretary, to be appointed by the President by and with the advice of the Senate, the Director of the Office of Vocational Rehabilitation, a representative of the Children's Bureau, a representative of the PHS designated by the Surgeon General and a representative of the Civil Service Commission. The President of the Commission is to receive \$15,000 per annum; the Secretary, \$12,000; the Executive Assistant designated from the members by the President, \$10,000 and the other members \$9,000. All members of the Commission will serve for ten years and are eligible for reappointment. The function of the Commission is to *provide medical, surgical, therapeutic treatment*, application of prosthetic or orthopedic appliances, hearing aids, eye glasses, and such other devices as may, by their use enable physically handicapped to become proficient physically; to provide education and training; and suitable employment through proper placement. There is authorized to be appropriated \$5,000,000 to set up

a revolving loan fund for personal catastrophe. A *Personal Catastrophe* is defined as any injury, disease or defect such that the use of a prosthetic or orthopedic appliance, hearing aid, eyeglasses, or other devices, would enable the individual affected to return to useful and gainful employment. These loans, bearing an interest rate of 2 per cent per annum, are limited to \$500 and are to be repaid by monthly installments. Physically handicapped who are totally and permanently disabled and without means of livelihood or support shall receive \$50 monthly. Authorization for an appropriation of \$10,000,000 for the fiscal year 1948 and \$5,000,000 for the next five years for establishing and *maintaining special industries* for the physically handicapped is given. An additional authorization for an appropriation of \$2,000,000 is made for *outright grants to local non profit groups to provide* means of teaching and training physically handicapped confined to their homes or beds.

### New Federal Security Administrator

Mr. Watson Miller resigned the office of Administrator of Federal Security Agency on August 18 and the resignation was accepted by the President on the 19th. This move was made to allow Mr. Miller to accept the position as Commissioner of Immigration and Naturalization.

Replacing Mr. Miller is Oscar Ewing who was a classmate of Paul V. McNutt and Wendell Willkie at the University of Indiana. He was editor of the *Harvard Law Review* with Senators Robert Taft and Owen Brewster. He practiced law with Charles E. Hughes—father and son. In 1940 he was the Assistant Chairman of the National Democratic Committee.

### Provisions for Appointment Regular Army Medical and Dental Corps Officers

Provisions have been made for the appointment of persons qualified for commissioned grades in the Medical Corps and Dental Corps of the Regular Army from three sources in addition to the current Regular Army integration program. Appointments to either corps will be made in the grade of first lieutenant with a minimum and maximum age on date of appointment of 21 to 32 years. The sources from which these appointments will be made are:

From persons who have completed a one-year internship in any Army hospital, are graduates of an

approved medical or dental school, and are recommended for appointment in the Regular Army by the intern board of the hospital in which the candidate served his internship.

From medical and dental officers of the Officers' Reserve Corps, National Guard of the United States, and Army of the United States who have demonstrated their fitness to hold commissioned grade in the Medical Corps or Dental Corps of the Regular Army, after having performed at least one year of continuous extended active duty after June 30, 1947, and are recommended by the commanding officers under whom they performed such active duty, are graduates of an approved medical or dental school, and, if candidates for the Medical Corps, have successfully completed one year's internship in an approved hospital.

Direct appointment of any qualified person, military or civilian, who is a graduate of an approved medical or dental school as a result of a competitive professional examination prepared and administered by The Surgeon General. Candidates for the Medical Corps must successfully have completed one year's internship in an approved hospital.

### Discharge of Medical Officers Liberalized

The War Department announced a streamlining of discharge criteria for all Medical Department officers effective July 1. All non volunteer doctors, dentists, dietitians, Veterinary and Sanitary Corps officers will be eligible for separation upon completion of two years' service. Nurses, physical therapists, and officers of the Medical Administrative Corps except those who have volunteered for extended active duty will be eligible for immediate separation.

Critically needed medical officers can still be individually retained where it is essential for the proper care of patients, the announcement stated. At present there are thirty-six specialists being retained as essential in Army hospitals.

Major General Raymond W. Bliss, newly appointed Surgeon General, explained that this new demobilization plan will permit the separation of medical specialists who previously have been subject to three years' service. General Bliss emphasized an important advantage of the plan is that it will facilitate the reclassification of young doctors in specialist grade.

Service requirements for members of both the



Veterinary and Sanitary Corps will be reduced from thirty-two months to twenty-four months. Practically all non volunteer Medical Administrative Corps officers and Physical Therapists have already been separated and the reduction in length of service requirements will affect only a handful of these officers. There is no change for dentists, dietitians and nurses.

### **Medical Corps Reserve Officers Training Corps Program 1947-48**

The Army Medical Department Plan for peacetime operations requires that Medical Corps ROTC units be established and operated at sixty-six medical schools which are approved by the Council on Medical Education and Hospitals of the American Medical Association. It is contemplated that these units should obtain a total enrollment of approximately 8,000 students for all four classes and that they should be able to produce approximately 2,000 first lieutenants for the Medical Reserve Corps, beginning with the end of the academic year 1949-50.

During the past year such units were in operation in twenty schools which participated in the program prior to World War II. Since the units were just getting under way again, the total enrollment was only 481 students in all classes. No senior medical ROTC students were graduated, hence none were tendered reserve commissions. However, this is considered to be a good beginning.

Units will be organized at twenty-three new schools for the academic year 1947-48, thus bringing the number of medical units up to forty-three. The remainder of the sixty-six schools will be contacted in the near future for the purpose of arranging for the activation of units for the year 1948-49. This is an ambitious program, however, it is thoroughly in keeping with the personnel requirements for medical corps officers in all of the various components of the Medical Department.

The course of instruction has been revised in keeping with the recommendations of the medical colleges and the experience of the medical service. It is designed to give the student progressive knowledge of the Army in general and the Medical Department in detail, together with familiarization with the many complex problems of military preventive medicine. Upon satisfactory completion

of the academic and ROTC curriculum and the six weeks summer training period, the young reserve first lieutenant should be capable of taking care of himself in the Army and performing the functions of a general duty medical officer in positions which do not require leadership. Should he, if on active duty, be assigned to a troop unit he must be given further training.

Regular Army medical officers are being assigned as Professors of Military Science and Tactics for these units. For the most part these are individuals who have had combat experience and are in the younger age group. They are being given the opportunity to participate in graduate professional specialty training which will be credited toward the requirements for admission to the examinations given by the various American Specialty Boards. The provisions of paragraph 35 of AR 145-10 have been waived by the War Department for medical ROTC instructors. This arrangement will be mutually beneficial to the ROTC program and to the Graduate Professional Education Program. It is contemplated that this arrangement will be made permanent. The professional training is being given in the form of a residency or a fellowship in the specialty in which the officer is interested. Tours of PMS&T duty are for a minimum of two years. Ample time is available for professional study in each case. These assignments are considered to be choice opportunities by those officers who are interested in obtaining certification by one of the established specialty boards.

A total of some forty-three Medical Colleges will operate medical ROTC units for the academic year 1947-48.

### **Navy Medical Corps Examinations**

Examinations to select candidates for appointment as assistant surgeon, with the rank of lieutenant, junior grade, in the Medical Corps of the Navy will be held at all Naval hospitals during the period October 6 through October 10.

Graduates of approved medical schools in the United States and Canada who have completed intern training in accredited hospitals within four months of the examination, and who are physically and otherwise qualified, may be examined for appointment. Candidates must be less than thirty-two year of age at time of appointment.

## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*

EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven

JOSEPH N. D'ESOP, New Haven

### Treatment of Disabled Veterans

Disabled veterans training under Public Law 16, the Vocational Rehabilitation Act, may be treated for any disability, service-connected or otherwise, if in the opinion of the Chief Medical Officer such treatment is necessary to prevent interruption of training.

In a recent memorandum, Harry T. Wood, manager of the Hartford Veterans Administration Regional Office, stated that, although VA medical facilities must be fully utilized in such cases, the veteran may request authorization for treatment by a private physician if use of these facilities would create undue hardship or further interrupt training. Authorization for treatment in these cases must always be obtained in advance, it was pointed out.

### Change in Requirements

The War Assets Administration has announced the following change in requirements for veteran purchasers of surplus property:

"The pre-sale certification requirement for veterans of World War II to purchase surplus property from War Assets Administration have been removed. This action comprises all war surplus in the War Assets Administration inventory except real property, aircraft, special industry and agricultural machinery and certain other machinery and equipment. It is designed to effect a more widespread distribution of surplus personal property to potential veteran purchasers instead of restricting it to the much smaller number of veterans who are qualified to purchase under the former certification procedure.

"The new procedure is quite simple from the point of view of the veteran purchaser. In general it requires but two things from him: (1) assurance that he is an honorably discharged veteran of World War II and (2) that he is not purchasing the property for the benefit of any other person or persons. A short form has been prepared for the veteran to fill out and sign which will provide the information

required above. This form can be filled out and signed by the veteran at any Customer Service Center at the time he is making his purchase, and to facilitate sales by mail, this form will be incorporated in all brochures of sales in which veterans participate.

"This newly established procedure should simplify purchase of government surplus property due to the fact that the lengthy pre-sale certification procedure has in the main been eliminated."

### VA Extends Compensation to TB Patients

Veterans Administration has announced it will extend compensation payments to veterans who have been discharged from VA hospitals with arrested pulmonary tuberculosis but who need more time at home in which to recover sufficiently to take a job without endangering their health. The new plan permits payments to these veterans on a totally disabled basis up to two years from date of discharge from any VA hospital while they remain under close medical supervision. Previously, the payments were reduced by 50 per cent within six months of the veteran's discharge.

Under the new plan, these veterans will be examined every six months. If the examination indicates they are unable to resume employment safely, physicians will certify their findings so that VA may determine whether to continue full compensation payments for an additional six months. VA expects this plan to result in better control of arrested pulmonary tuberculosis among veterans and thus reduce the necessity of hospitalizing them again. Identified as Instruction No. 4, dated July 14, 1947, the Administrator's extension order directs examination of these arrested cases within six months from the veteran's release from a VA or a service hospital or from the date of his last examination.

If the tuberculosis specialist making the examination finds that the veteran is suffering from arrested pulmonary tuberculosis in a convalescent stage, he fills out a certificate which is forwarded by medical



authorities of the VA regional office having jurisdiction over the veteran's case folder to VA's adjudicating division for review and authorization of continued full compensation. The examining specialist is required to state, in accord with the findings, that the veteran's condition "precludes his employment and requires special medical rehabilitation under a suitable program of limited activity, in a sheltered workshop or his home, under frequent medical supervision."

The instruction has been circulated among VA field offices for immediate application. Many prominent tuberculosis specialists and medical rehabilitation experts have long advocated this action, VA said. They characterize it as one of the most promising advances in the care of tuberculosis by VA.

## Medical and Hospitalization Functions of VA

One of VA's most important services is medical care—second to none—for ill and disabled veterans. The national network of modern, well equipped and properly staffed hospitals is moving gradually from the planning to the operational stage.

The 124 hospitals now operated by VA include a number of temporary structures declared surplus by the armed services.

Completion of the 90 new hospitals in the present construction program will permit a more satisfactory distribution of VA's hospitals over the United States.

The resident training program, in which VA is training doctors for the many specialties it requires, is in full operation. Many of the 1,867 doctors receiving this training in VA hospitals will join the full time medical staff later.

This staff on August 1, 1947 totaled 3,630 doctors. On that date, VA also was using the part time services of 2,536 consultants and fee-basis doctors.

Since its establishment less than two years ago, the Department of Medicine and Surgery has stepped up the monthly rate of discharges in its hospitals from 28 to 40 per cent of the average number of patients in the hospitals. The average period of hospitalization is expected to be cut further as a result of various research projects now under way.

In addition to the thousands of veterans treated in VA hospitals, the outpatient service has expanded

its activities several fold during the last two years. More than 175,000 veterans are examined each month under this program, and 154,000 are receiving treatment.

Under a similar dental program, 70,000 veterans are being examined monthly and 45,000 treated. Private dentists are assisting VA dentists in this program through a home-town care plan.

## VA Residency Training

Veterans Administration is making every effort to encourage doctors who complete residency training in one of its hospitals to accept fulltime probational appointments in the VA's Department of Medicine and Surgery. Upon the satisfactory completion of three years' probational work, appointments are made permanent. Every effort is made to place these doctors in positions where they may practice their specialties and best serve ill and disabled veterans.

American Specialty Boards require that doctors, upon completion of formal residency training, serve additional time in the practice of their specialties under the guidance of certified specialists, who may be either fulltime employees or consultants, to qualify for the Specialty Boards of their choice.

VA offers such guidance to doctors who will serve in VA hospitals, both during and after completion of residency training. Guidance in the field of psychiatry also is offered in mental hygiene clinics where the chief of clinic has not been certified by the American Board of Neurology and Psychiatry, provided the chief is a capable specialist. In many fields, such as dermatology, ophthalmology and otolaryngology, guidance might also be received by doctors at regional offices.

VA has training programs under way in 62 of its 124 hospitals, with 1,770 residents studying for their specialty boards. This training program is a vital source for the recruitment of permanent doctors for VA's Department of Medicine and Surgery and is an important feature of VA's program to provide eligible veterans with medical care "second-to-none."

## VA Offers Residency Training in Tuberculosis

Veterans Administration will offer physicians residency type training in tuberculosis for the first time in its history, according to an announcement

by Dr. Paul R. Hawley, VA's chief medical director. The training program was approved by the American Medical Association. Five VA hospitals where training will be available are in Brecksville, Ohio; Alexandria, La.; Excelsior Springs, Mo.; Oteen, N. C.; and McKinney, Texas.

Although the hospitals at Alexandria and Oteen are not now associated with medical schools under the VA Dean's Committee plan, physicians serving there may earn credit toward the examinations of the American Specialty Board for Internal Medicine and its sub-specialty board for tuberculosis. The other three VA hospitals are affiliated with medical schools under the Deans' Committee program.

### VA Offices Close

Veterans Administration offices in Ansonia, Bristol, Manchester, Meriden, South Norwalk, Torrington, and Winsted discontinued fulltime operations on September 30.

Harry T. Wood, manager of the Hartford Regional Office of the Veterans Administration, has announced that a program of contact services will replace fulltime activities in these communities. The closing of the seven offices was necessitated by a reduction of personnel in vocational rehabilitation and contact work, it was said.

The following VA offices will continue to operate on a fulltime basis: Hartford, Bridgeport, New Haven, Middletown, New Britain, New London, Norwich, Stamford, Waterbury, and the contact office located at the Veterans Hospital in Newington.

### Dr. Leonard Goes to New Orleans

George A. Leonard, formerly a Waterbury physician, has been appointed chief medical officer of the Veterans Administration Regional Office in New Orleans. He discontinued his Waterbury practice in 1940 to enter the Army Medical Corps, and for some time has been a medical officer at the VA headquarters in New Orleans.

### Pharmacies Enrolled in Home Town Medical Care Program

The following pharmacies have been enrolled in the home town medical care program for Connecticut veterans since publication of the original list in the August issue of the STATE MEDICAL JOURNAL, according to a report furnished by the Con-

necticut Pharmaceutical Association:

All Liggett stores in Connecticut

Robert L. Blume, 3 Maple St., Ansonia

College Pharmacy, 768 Boston Ave., Bridgeport

Doctor's Pharmacy, 881 Lafayette St., Bridgeport

Meads' Medical Arts Drug Store, 1299 Main St., Bridgeport

North End Pharmacy, 3945 Main St., Bridgeport

Stratfield Pharmacy, 1244 Stratfield Road, Bridgeport

Noveck's Pharmacy, 1 Divinity St., Bristol

Kinner's Drug Store, 173 Main St., Danbury

Rudy's Rexall Drug Store, Danielson

Blume's Pharmacy, 53 Elizabeth St., Derby

Hamden Pharmacy, 1150 Dixwell Ave., Hamden

Arthur Drug Stores, Inc., Hartford

Beacon Drug Co., 1081 Capitol Ave., Hartford

Percy G. S. Buck, 1 New Britain Ave., Hartford

Champlain Drug Co., 1957 Park St., Hartford

Ideal Drug Co., 1 Wethersfield Ave., Hartford

Trinity Drug Co., 1284 Broad St., Hartford

Zito's Pharmacy, 723 Wethersfield Ave., Hartford

Arthur Drug Stores, Inc., Manchester

Graeber's Pharmacies, 180 West Main St.,

143 Pratt St., Meriden

Pigeon's Pharmacy, 445 Colony St., Meriden

John T. Howe Drug Store, 58 Broad St., Milford

Raphael E. Ford, 2 Church St., Naugatuck

G. F. McKenna, 174 Church St., Naugatuck

Zackin Pharmacy, 42 West Main St., New Britain

Granniss Corner Pharmacy, 418 Forbes Ave., New Haven

Morris Cove Pharmacy, 101 Townsend Ave., New Haven

Pequot Drug Store, 106 Grand Ave., New Haven

Prospect Pharmacy, 586 Winchester Ave., New Haven

Taft Pharmacy, 75 College St., New Haven

Wolfson's Drug Store, 203 Whalley Ave., New Haven

Court Drug Co., 331 State St., New London

James Drug Co., 181 Bank St., New London

Harold A. Mead, 520 West Ave., Norwalk

Lerou's Drug Store, 289 Main St., Norwalk

Spooner Drug Co., 149 Main St., Oakville

Arthur Drug Stores, Inc., Rockville

Shelton Drug Store, Rowe Ave. and Bridge St., Shelton

McCormick Drug Co., Stafford Springs

Louis O. Levine, 269 Bedford St., Stamford

Thorne's Pharmacy, 921 East Main St., Stamford

F. B. Winski, 743 Atlantic St., Stamford

Sears Pharmacy, 2392 Main St., Stratford

Torrington Pharmacy, 110 East Main St., Torrington

Washington Pharmacy, Washington Depot

Brewster Pharmacy, 928 North Main St., Waterbury

Fairlawn Pharmacy, 222 Frost Road, Waterbury

Fulton Park Pharmacy, 194 Cooke St., Waterbury

Ideal Pharmacy, 178 North Main St., Waterbury

William R. Kenausis, 945 Bank St., Waterbury

Paul J. Kunkel, 1804 East Main St., Waterbury

McCarthy Pharmacy, 2 Grove St., Waterbury

Tareila's Drug Store, 826 Bank St., Waterbury

Vanderman Drug Co., 371 East Main St., Waterbury

Washington Hill Pharmacy, Baldwin St., Waterbury

Daniel G. Sullivan, Watertown

Hickey Drug Co., 84 Union St., Willimantic

Wilson Drug Co., 396 Windsor Ave., Wilson

C. Leo Higgins, 39 West Broad St., Westerly, R. I.



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## STATE DEPARTMENT OF HEALTH

STANLEY H. OSBORN, M.D., Commissioner

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### EMIC Program Starts to Close Up Shop

After more than four years in operation, the wartime program for emergency maternity and infant care began closing its books on July 1, 1947. Under this plan, maternity care was provided for servicemen's wives as well as medical, hospital and nursing care for their infants throughout the first year of life. Between March 1943 and June 30, 1947 the U. S. Children's Bureau, Social Security Administration, Federal Security Agency reported 1,421,000 cases either completed or approved for care. Wives and infants of men in the four lowest pay grades of the armed forces, and of aviation cadets were eligible for the services provided. The EMIC program was administered by state health departments under plans approved by the Children's Bureau.

The Connecticut State Department of Health approved the EMIC plan in May 1943. Between that time and June 30 of this year the bureau of maternal and child hygiene authorized care for 13,400 maternity patients and 4,255 infants. This involved the expenditure of \$2,009,720 in federal funds which had been allocated to Connecticut for this specific purpose. Up to June 30, 1947 over \$214,900,000 was allotted to the 48 states to cover the costs of the EMIC program. For the fiscal years of 1947-48 and 1948-49, Congress appropriated another \$3,000,000 to be used in liquidating the program. During the past six months this "stork bill" has averaged about \$100 a baby; while the average cost of caring for a sick infant came to \$67. Up to the present, hospitals received about \$63,500,000 and doctors about \$50,500,000 out of the total amount disbursed by the various states.

Though Congress has directed the liquidation of the Emergency Maternity and Infant Care program in its appropriation to the Children's Bureau for 1947-48, the plan has for some time been drawing to an end. Cases approved for care dropped to a national average of 9,300 a month in comparison to 47,000 during a peak month of the war years. Connecticut has experienced a similar decrease with an average of 140 cases approved each month in 1947,

in contrast to 621 during the peak month. Although machinery has already been set in motion for liquidation of the plan, the books of the EMIC program will not be finally closed for at least another 21 months. Full time care will still be provided to all wives and infants now receiving care and for all those eligible for care as of June 30, 1947. This means that EMIC services are extended to any eligible serviceman's wife and child if wife was pregnant June 30, 1947 even though application for care was not made before this time. Care will be given to the wife and to the infant until he is one year of age. Applications should still be made to private physicians or state health departments.

Begun as an emergency measure, the EMIC program turned out to be the largest public medical care plan for mothers and children ever undertaken in this country. At its height, one out of every seven babies born in the United States was born under the EMIC program. During the fiscal year 1945, over 48,000 doctors in private practice, and hospitals all over the country cooperated in the EMIC plan. Even under wartime difficulties an all-time record for hospital deliveries was established. More than 92 out of 100 babies born under the EMIC program in 1945 were born in hospitals. When all births for 1945 were studied however, only 79 of every 100 occurred in hospitals. Even this proportion was higher than prewar figures. The U. S. Children's Bureau pointed out that this increase was due to the fact that many mothers who were delivered in hospitals under the EMIC program were from population groups that ordinarily had their babies at home, with only an untrained midwife in attendance.

Of the 32,436 babies born in Connecticut in 1945, 32,415 were delivered by physicians and 98.4 per cent out of every 100 births occurred in hospitals. For EMIC patients, 99.3 per cent were delivered in hospitals. Standards of prenatal care for EMIC were set by the state department of health upon advice from the Connecticut State Medical Society; for example, 8 prenatal visits were required for the complete prenatal fee for EMIC cases.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, MRS. ROBERT J. COOK, New Haven  
*President-Elect*, MRS. HAROLD W. WELLINGTON, New London  
*First Vice-President*, MRS. CHARLES W. GOFF, West Hartford  
*Second Vice-President*, MRS. JAMES DOUGLAS GOLD, Bridgeport

*Recording Secretary*, MRS. F. ERWIN TRACY, Middletown  
*Corresponding Secretary*, MRS. EDWIN R. CONNORS, Bridgeport  
*Treasurer*, MRS. FRANK DiSTASIO, New Haven

### Board Meeting

August 7, 1947 will be a day long remembered by the Board of Directors of the Woman's Auxiliary to the Connecticut State Medical Society, for on that day Mrs. Harold W. Wellington, president-elect, opened her beach house in New London for a Board meeting.

Above a window, from which is the magnificent view of the beach and sound, there is written the following: "The ornaments of this house are the guests who visit here." The ornaments on that particular day were: Mesdames Robert J. Cook, Harold W. Wellington, Charles W. Goff, James D. Gold, Edwin R. Connors, Dewey Katz, Edward Ottenheimer, Paul S. Phelps, William Mac Shepard, Creighton Barker, Chester E. Haberlin, F. Erwin Tracy, Paul W. Tisher, C. Tyson Hewes, Winfield Wight, Morton Arnold, Edgar C. Yerbury. Very attractive ornaments, if I do say so—and shouldn't.

Swimming was enjoyed by some preceding a delicious luncheon. Dr. Harold Wellington stopped by for a short pleasant chat.

After all of these pleasantries, everyone settled down to the serious business of the day. The meeting was called to order by our president, Mrs. Cook, at 1:30 P. M. The treasurer was not present but Mrs. Cook reported a balance of \$625.27, August 1, 1947. There is an outstanding bill for the printing of the Constitution and By-Laws for \$110. Mrs. Cook spoke briefly on the National Convention at Atlantic City on June 9 to 13, inclusive. Mrs. Eustace Allen of Atlanta, Ga., is the new president of the Auxiliary, while Mrs. Kice of New York City, formerly National legislative chairman, is president-elect. The highlights of the meeting were the reports of the State presidents. Mrs. Gold gave an excellent report. (CONNECTICUT STATE MEDICAL JOURNAL—September). Mrs. Cook further stated that the doctors in Oregon and Montana include in their annual dues the dues of the Auxiliary, *Hygeia*

and the Auxiliary Bulletin, thereby making a 100 per cent membership for their auxiliaries. (Connecticut doctors please note.) The Auxiliary membership is over 36,000 with 726 Auxiliaries in the United States. There were 2,205 registered.

### County Presidents Reports

#### FAIRFIELD

Mrs. Haberlin reported for Mrs. Oliver Stringfield, president, who was unable to be present. A box luncheon was held at Pequot for the benefit of the Laurel Heights Sanatorium project. Mrs. Lambert was the hostess and Mrs. Cook and Mrs. Barker were guests. Forty dollars was cleared.

#### HARTFORD

Mrs. Paul W. Tisher, president, said that the "get-acquainted" luncheon-bridge held at the Shuttle Meadow Club, New Britain, on June 2 was most successful. Seventy-five members were present. A luncheon Board meeting was held at the home of the president on June 17 at which time plans were made for the coming year. The fall meeting will be held on October 25. Plans are also under way for a musicale to be given for the benefit of the Welfare Fund. It is hoped that the welfare project may become active this fall. A directory of the officers and committee chairmen and plans for the year is to be printed shortly.

#### WINDHAM

A July luncheon meeting with Dr. Dayton from Mansfield Training School as the speaker was reported by Mrs. Morton Arnold, president. A motion was passed at this meeting that members of their Auxiliary approved as a project for this year assistance to the State mental hospitals and would be available when notified by the State Auxiliary.

#### MIDDLESEX

A luncheon board meeting was held at the home of the president, Mrs. Edgar C. Yerbury, at which



time questionnaires were discussed. These are to be sent out early in the fall to discover the interests, ideas and talents of the membership.

### Reports of Standing Committees

Below are listed new appointments.

Finance—Mrs. Edward Ottenheimer, Windham.

Publicity—Mrs. Paul S. Phelps, R. F. D. 1, Collinsville.

Public Relations—Mrs. William Mac Shepard, R. F. D. 2, Putnam.

Hospitality—Mrs. Joseph H. Howard, 122 Eastwood Road, Bridgeport 4.

Mrs. Creighton Barker and Mrs. Cook represented the Auxiliary at the Rural Health Program meeting at the University of Connecticut. Pamphlets which explained the program in detail were passed to the Board members. Mrs. Barker also suggested that interested organizations be urged to attend such meeting by the Woman's Auxiliary.

That great stress was placed on Rural Health Education at the National meeting in Atlantic City was reported by Mrs. Dewey Katz, *Hygeia* chairman. Mrs. Katz has asked permission to send a *Hygeia* exhibit to future health conferences held in Connecticut. *Hygeia*, too, is a service offered by the medical profession to the layman for a nominal fee.

The following motion was made, seconded and unanimously carried: "That the Board of Directors recommends to the County presidents and treasurers that they include on their annual bills the subscription price of *Hygeia*."

Mrs. Charles W. Goff, first vice-president, hopes that every County chairman of organization and membership will attend the meeting to be called to make plans for membership. At the end of the year, each County chairman of organization and membership should submit a report to her so as to give her material for her report. The following motion was made, seconded and carried: "That the Board of Directors recommends to the County chairmen of membership that they see to it that non members who are eligible be invited as guests."

The National historian requested that Mrs. James D. Gold, our retiring Connecticut State president, write a detailed report of the year's activities. Mrs.

Gold also gave a two minute summary of the year's report at Atlantic City. (CONNECTICUT STATE MEDICAL JOURNAL—September.) Mrs. Gold is completing plans for the Auxiliary fall meeting. This may be held in December at the time of the meeting of the House of Delegates. Complete details will be announced later and will be most interesting.

In the absence of Mrs. G. Gardner Russell, legislative chairman, Mrs. Cook reported briefly on the following bills, pending in Congress: Taft-545; S1234; Taft-140.

Dr. Joseph H. Howard was going to Washington to sum up arguments of medical people, but all hearings have been called off until January.

Mrs. William Mac Shepard, public relations chairman, stated that education was the most pertinent question at this time since there is a lull in legislation. The following motion was made, seconded and unanimously approved: "That Mrs. Mac Shepard organize a speaker's Bureau." This bureau would consist of a few wives of physicians who would be prepared to speak to various organizations. Mrs. Cook felt that we should have different projects from which to choose so as to use the energies of all our membership.

Each County publicity chairman has received a letter from Mrs. Paul S. Phelps, State publicity chairman, requesting that material for the JOURNAL be received by her on the first day of each month. Mrs. Phelps also requests the County presidents to tell their publicity chairman to send a representative to all meetings, if they are unable to attend.

A meeting of the Board of Directors, State chairmen and County chairmen will be held in Hartford. The morning to be devoted to meetings of the County chairmen with their respective State chairmen, while the afternoon will be a meeting of the entire group with a well known speaker.

At the National meeting, each State president was urged to appoint a State chairman on medical care plan, so that the Board of Directors would be informed on the progress being made in their State. A motion was made, seconded and carried that Mrs. Cook appoint a State chairman of medical care plan.

The meeting adjourned at 3:30 P. M., each member leaving with the feeling of a day exceedingly well spent.

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## OBITUARIES

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### H. Wilson Fancher, M.D.

1899 - 1947

Henry Wilson Fancher was born in Newtown, Connecticut, on November 11, 1899, son of Henry W. Fancher and Grace Morris Fancher. Most of his early life was spent in Winsted where he attended the local schools, including Gilbert High School. He received a B.S. degree in 1921 from St. John's Academy, Annapolis, and his medical degree from the University of Maryland in 1925. Internship appointments were served at West Baltimore General Hospital and New Britain Hospital. He entered general practice in Thompsonville on February 21, 1926.

During the next twenty years Dr. Fancher faithfully served the interests of his community. He conducted an extremely busy general practice and was vigilant in keeping abreast of new medical developments, using these in the service of his patients.

He was a member of Hartford County Medical Association and American Medical Association, attending many of the conventions.

Besides his medical work he found time for many other activities. He was instrumental in organizing the local troop of Boy Scouts of America. He was a charter member and past president of the Rotary Club. He belonged to the Tanguay-Magill Chapter of the American Legion and had served as commander of the Post. He was also a member of the Mystic Lodge of Masons.

Dr. Fancher was married in 1925 to Bernice Schaale of Baltimore. They have one daughter, Priscilla King Fancher, and one son, Henry Wilson Fancher, Jr. Mrs. Fancher and the two children survive.

During the war years Dr. Fancher assumed extra duties with the Civilian Defense Council and as examining physician with the Induction Center for the area. Further burdens were imposed by absence of other doctors with the Armed Services and the deaths of two at home. In 1943, Dr. Fancher was instrumental in forming the Enfield Medical Association, and served as its secretary. The purpose of

this association was to coordinate the activities of local physicians for better community service.

A roster was drawn up to assure the presence of a physician in town to cover emergency calls on weekends and midweek days when most physicians were off. A list of the doctors on call was printed and distributed to individual homes by the Enfield Milk Dealers. Through the cooperative efforts of the doctors and the police department community needs were thus met with diminished personnel. This practice has been continued into peace time, with benefit to all concerned.

Through these strenuous years Dr. Fancher enjoyed good health until March 19, 1947, when he was stricken with a heart attack which resulted in death within a few minutes. Taken suddenly at the age of forty-seven in the years of his prime, he is sadly missed by his patients and colleagues alike.

Howard W. Gourlie, M.D.

### Howard S. Allen, M.D.

1882 - 1947

In the death of Dr. Howard S. Allen the towns of Roxbury, Southbury, Bethlehem and Woodbury lost not only a capable medical adviser but a valued friend and counsellor.

Dr. Allen was born in Woodbury May 18, 1882 and was a lifetime resident except for the years of medical study and internship. He died July 5, 1947.

He was the son of Julius and Lillian Sanford Allen. He graduated from Yale Medical School in 1904 and served a two-year internship at St. Mark's Hospital, New York City. He began his practice in Woodbury in 1906 and later served as medical examiner and health officer, positions which he held until his death.

He had a continuing interest in all town affairs where his advice and counsel were held to be of great value. He was a member of the School Board for thirty-one years and secretary of that body for several years. He was a member of the Litchfield County Medical Association and of King Solomon's Lodge of Masons in Woodbury.

An enthusiastic follower of sports, Dr. Allen at



one time was prominent as a baseball player and at Yale was an important pitcher on the Varsity team. In later years he became an expert in golf.

In spite of many years of ill health, he courageously kept on with his practice, refusing to retire from an active life to one of leisure and more physical comfort.

He is survived by his wife, the former Grace Judson; by a daughter, Mrs. Delmar A. Knox; and by two grandchildren, residents of Litchfield.

Robert Hazen, M.D.

### Donald Brett Cragin, M.D.

1875 - 1947

Dr. Donald Brett Cragin, Medical Director of the Ætna Life Insurance Company, died at his home, 1414 Asylum Avenue, Hartford, on Sunday, July 13, 1947.

Dr. Cragin was born in Farmington, Maine, on November 18, 1875, of a long line of early New England ancestors. He was a descendant of John Alden and Governor Belcher of Massachusetts.

He graduated from the Farmington State Normal School, Farmington, Maine, following which he taught for a period at the Fryeburg, Maine, High School.

He entered Harvard Medical School in the Class of 1902. Following his graduation he accepted a surgical internship at the Carney Hospital, Boston. At the completion of his hospital service he began his practice in the town of Waterville, Maine, in July 1904. After a short period he then established and organized his own hospital and as surgeon-in-chief he successfully carried on a large surgical practice in this community.

In 1917, with our participation in World War I, he entered the service as a Captain in the Army Medical Corps. Much of his service was spent as chief of the surgical service at Fort McPherson, near Atlanta, Georgia. Upon the completion of the war he came to Hartford in 1920 and established a practice in surgery.

In 1924 he joined the medical staff of the Ætna Life Insurance Company under the late Dr. Edward K. Root as an associate medical director. Upon the retirement of Dr. Root in 1933 he was made medi-

cal director of this corporation.

In 1940 he was elected president of the Association of Life Insurance Medical Directors of America and also served for two years as chairman of the medical section of the American Life Convention.

While active in public life he was prominently identified with the Democratic party and in 1925 was appointed a member of the Board of Health of Hartford. In 1927 and 1932 he was president of this Board and in 1933 was appointed to the Welfare Board.

He was active in the Connecticut State Medical Society, Hartford Medical Society, a Fellow of the American College of Surgeons, and a member of the American Medical Association. He was consulting surgeon of the Hartford Hospital, trustee of the Hartford Dispensary.

He was a member of the Unitarian Church, the University Club, the Hartford Golf Club, the Twentieth Century Club, and the Hartford Oratorio Society, serving as president of this society in 1933.

He leaves his wife, Mrs. Reata King Cragin, and a son, George Stevenson Cragin, of Boston; a sister, Miss Jean Cragin of Boston; and a brother, Abbott Cragin of Waterville, Maine.

Dr. Cragin held many important offices in national and local medical organizations. He was an outstanding leader in the field of insurance medicine. His contribution and leadership in the insurance field were outstanding and much of his work will be reflected by those associated with this branch of medicine. He was a cultured, keen, and broad-minded physician with many interests. He had throughout his life a student's trend of mind and as a hobby his collection of rare hand-tooled first editions was the envy of many. Books, travel, and music were his great interests. As a resident of Maine in his younger days he enjoyed hunting and fishing. His wit and genial personality will be recalled by his many friends. He was a true friend and his kind and wise counsel, his conversational ability, and his broad interests made for him a large place in life. The profession of medicine and the insurance business will miss the help and leadership of this cultured doctor whose influence will long be felt.

Parker M. Cort, M.D.

## SPECIAL NOTICES

### INDUSTRIAL HEALTH CONGRESS TO BE HELD IN CLEVELAND

The eighth annual Congress on Industrial Health, previously planned for October 8, 9 and 10 in Detroit, will be held instead at Cleveland, Ohio, on January 5 and 6 in conjunction with the mid-winter meeting of the House of Delegates of the American Medical Association.

The Detroit plans were canceled some time ago because the October dates conflicted with the annual meeting of the American Public Health Association.

The program for the Congress on Industrial Health is now being formulated and will be announced soon.

### HEADQUARTERS OF THE COMMANDANT THIRD NAVAL DISTRICT

Federal Office Building, 90 Church Street  
New York 7, N. Y.

Captain M. Brooks, MC-USNR, Medical Representative to the Commandant (District Director Naval Reserve) announces the second of a series of monthly medical meetings.

All U.S. Navy and U.S. Naval Reserve Medical Department personnel, and civilian doctors, dentists and students are invited to attend.

#### MEDICAL MEETING

TUESDAY EVENING, 14 OCTOBER 1947, AT 2000

The New York Academy of Medicine—Room 440. 2 East 103rd Street, New York, N. Y.—Phone: ATwater 9-4700.

1. Motion Picture: Introduction to Combat Fatigue. Official Navy Film MN-3428 a.

2. Neurology in the Navy, World War II. Comdr. Orman C. Perkins, MC-USNR, Professor, Neurology and Psychiatry, Long Island College of Medicine.

Discussion: Comdr. Bruce L. Kendall, MC-USN, Chief of Neuro-psychiatry, U.S. Naval Hospital, St. Albans, L. I., N. Y.

3. The Training and Function of a Naval Neuro-psychiatrist. Comdr. Harry B. Lang, MC-USNR, Assistant Commissioner, Department Mental Hygiene, State of New York.

Discussion: Comdr. Edgar A. P. Kellerman, MC-USNR, Resident Psychiatrist, Brooklyn State Hospital for Insane, Alternate Psychiatrist, Volunteer Medical Specialist Unit 3-1.

A. H. Dearing,

Rear Admiral MC-USN

District Medical officer

### COURSE IN ALLERGY

The American College of Allergists announces Fall Graduate Instructional Course in Allergy under the auspices College of Medicine, University of Cincinnati, Cincinnati, Ohio, November 3-8, 1947, inclusive, Hotel Headquarters—

Netherland Plaza. Lectures given in auditorium, Medical College, University of Cincinnati, Bethesda and Eden Avenues. Fee \$100.

Make all reservations for the course and hotel accommodations directly with the secretary, Dr. Fred W. Wittich, 423 LaSalle Medical Building, Minneapolis, Minnesota. In making your reservation please state the exact time of your arrival and departure and whether you want a single room or wish to share one with another registrant. The number of single rooms is limited.

### V.A. HOME TOWN MEDICAL CARE PROGRAM

Almost two years of operation have provided much in the way of experience concerning the operation of the Veterans Administration Home Town Medical Care Program.

How is the program working? What problems are proving difficult of solution? Where and why should changes be made in the program?

These and many more questions will be subjects of serious discussion at the A.M.A. headquarters in Chicago on November 6. On that day, which is one day prior to the Annual Secretaries and Editors Conference, representatives of the state medical societies and the Veterans Administration will be invited to participate in a conference on the Home Town Medical Care Program. The purpose of the conference is to bring out problems, discuss solutions of these problems and establish basic policies from which recommendations with some semblance of a united front can be made to the Veterans Administration.

### THE VAN METER PRIZE AWARD

The American Association for the Study of Goiter again offers the Van Meter Prize Award of Three Hundred Dollars and two honorable mentions for the best essays submitted concerning original work on problems related to the thyroid gland. The award will be made at the annual meeting of the Association which will be held in Toronto, Canada, May 6, 7, 8, 1948, providing essays of sufficient merit are presented in competition.

The competing essays may cover either clinical or research investigations; should not exceed three thousand words in length; must be presented in English; and a typewritten double spaced copy sent to the corresponding secretary, Dr. T. C. Davison, 207 Doctors Building, Atlanta 3, Georgia, not later than February 1, 1948. The committee who will review the manuscripts is composed of men well qualified to judge the merits of the competing essays.

A place will be reserved on the program of the annual meeting for presentation of the Prize Award Essay by the author if it is possible for him to attend. The essay will be published in the annual Proceedings of the Association. This will not prevent its further publication, however, in any *Journal* selected by the author.



## NEWS

### *from County Associations*

#### Fairfield

The Norwalk Medical Society held its annual outing August 13 at the Longshore Country Club in Westport.

John S. M. Hamilton, formerly of Stamford, is now at the 6th Army Station Hospital, Camp Stone-man, California.

#### Hartford

Crit Pharris, assistant medical director of United Aircraft Corporation, is the author of "Trends in Part-time Industrial Health Service" published in the August issue of the *Rhode Island Medical Journal*.

Clifton M. Cooley, for ten years medical examiner of New Britain, died in that city on September 5. Dr. Cooley is credited with having inaugurated the x-ray department at the New Britain General Hospital in 1913.

Three Hartford physicians, Carl S. Hellijas, Ralph M. Tovell, and Kerchival R. Holt, are the authors of "Analgesia and Anesthesia in Obstetrics," published in *Anesthesiology* and abstracted in *Digest of Treatment*.

Alva E. Abrams, formerly a physician of Hartford for almost fifty years and recently practising in La Jolla, California, died at his home in the latter city on August 24.

#### Litchfield

Manley Cohen, formerly resident in surgery at the Veterans' Hospital in Newington, has accepted residency at the Charlotte Hungerford Hospital. Dr. Cohen's home is in Boston. He is married and has a son.

At a recent meeting of the Thomaston Medical Society, Mr. James Burch addressed the doctors on the subject of public relations which he speaks of as "human relations." Mr. Burch is the public relations representative of the State Medical Society.

Benjamin Katzin, a native of Winsted, who has been recently discharged from the United States

Army and who served as a resident in medicine at the Veterans' Hospital in Newington, has opened an office in Torrington for the practice of internal medicine and cardiology.

J. F. Kilgus, Jr., and Albert W. Dautrich have recently moved into new offices on West Street in Litchfield.

Daniel Samson who has served as resident at the Charlotte Hungerford Hospital for the past year, is taking over the practice of Henry Atha in Thomaston. Dr. Atha has been forced, because of poor health, to give up his practice in Thomaston and hopes to resume practice in Arizona. Winfield Wight of Thomaston gave a dinner in honor of Dr. Atha at the Torrington Rod and Gun Club on Thursday, September 18. The dinner was well attended by Dr. Atha's professional friends.

#### Middlesex

George B. Davis, formerly of Milford, is now health officer of Middletown succeeding Dale E. Scholz who has entered the public health service in Illinois. Dr. Davis has been a member of the courtesy staff of Middlesex Hospital since the days when he practised medicine in Guilford and in Wethersfield. Prior to his appointment as health officer of Milford, Dr. Davis served as health officer in Kentucky from 1939 to 1942. He is a fellow of the American Public Health Association and president-elect of the Connecticut Public Health Association.

#### New Haven

Thomas M. Monagan has been appointed a school physician in Waterbury where he is engaged in the practice of pediatrics.

Aram Glorig is now director of the Audiology Center at the Walter Reed General Hospital, Washington, D. C.

William J. German of New Haven is the author of "Intracranial Aneurysms" published in the August issue of *The Journal of the Maine Medical Association*.

Thomas P. Murdock of Meriden is the author of "Modern Influences in Medical Practice" published in the April issue of the *Journal of the Michigan State Medical Society*.

Richard Rosenthal has been appointed school physician in Branford.

## New London

Harry E. Higgins, veteran physician and former town health officer, died in Norwich on August 8 a few days before his seventy-sixth birthday. Dr. Higgins was engaged in active practice from 1899 until his retirement in 1939.

## Tolland

William Schneider, Rockville, and Miss Betty Grossbach of Newark, N. J., were married in Rockville on August 30, 1947.

Siegfried Firestone, who had been in practice in Rockville for several months, closed his office and has taken a position with the Veterans Administration. He is stationed in South Carolina.

The semi-annual meeting of the Tolland County Medical Society will be held on October 21. The guest speaker will be announced at a later date.

## News from Yale University School of Medicine

In the March 1947 issue of *The Yale Journal of Biology and Medicine*, designated C.-E. A. Winslow Number, may be found many present and former members of our Society. One of our eminent associate members, Professor Ira V. Hiscock, is the author of the leading article entitled "Public Health at Yale." John R. Paul, professor of preventive medicine at Yale, contributes an article on "The Peripheral Spread of Poliomyelitis Through Rural and Urban Areas: Observations from a Recent Epidemic." Charles C. Wilson, professor of education and public health at Yale, contributes "Improving School Health Programs" and Martha M. Eliot, associate director of the U. S. Children's Bureau, is a co-author of "Four Years of EMIC Program." "Adequacy of Medical Care" is written by Franz Goldmann, clinical professor of public health at Yale. Clifford Kuh, now director of public health in the Permanente Foundations Hospital, Oakland, California, is the author of "Geriatrics in Industrial Medicine." William W. Peter, now director of the training division of the Institute of Inter-American Affairs, Washington, D. C., is the author of "A Hemisphere Health Program." In addition to the above there are many contributors of national reputation.

## NEW BOOKS IN REVIEW

*BEAUTY PLUS: THE KEY TO BEAUTY, HEALTH AND CHARM.* Author: Mary MacFadyen, M.D. New York: Emerson Books, Inc. 1947. 272 pp. \$2.49.

Reviewed by ANN DELAFIELD

For many years the American woman has felt a great need for a book that would tell her the simple scientific facts about her Beauty Life. Understandably, this book would have to be written by a medical authority—and a woman. At last we have that combination in Mary MacFadyen, M.D., who has written a truly comprehensive book entitled "Beauty Plus."

This book, first of all, destroys forever all the silly myths in regard to beauty culture that have been fed all too often to gullible females in the past. The careful reader will learn that there is no such thing as a "skin food" or "nourishing cream," and automatically will stop throwing away her dollars for such misleading cosmetics. Instead she will find recipes for making her own lotions and creams at home. In addition to these recipes, Dr. MacFadyen has worked out a simple daily beauty ritual that, if intelligently followed, can help any woman make herself a lovelier person from the top of her head to the tips of her toes. The exercises prescribed for contour control and posture work follow a fairly general pattern that is used in the world of physical education and particularly because of their general nature, will benefit most types of female figures.

The most precious part of the book to the average woman will be those chapters that simplify the physiology of the female. "Must" reading for all girls and women are the paragraphs on menstruation, pregnancy, and menopause. Here is the knowledge with which all mothers should be equipped but so few are able to convey to their daughters. Truly, Dr. Mary MacFadyen has, through this book, become "A woman's best friend!"

*HOSPITAL CARE IN THE UNITED STATES, A Study of the Function of the General Hospital, Its Role in the Care of All Types of Illness, and the Conduct of Activities Related to Patient Service, with Recommendations for Its Extension and Integration for More Adequate Care of the American Public. Report of the Commission on Hospital Care.* New York: The Commonwealth Fund. 1947. 631 pp. \$4.50.

Reviewed by STANLEY B. WELD

The Commission on Hospital Care was established in October 1944 by the American Hospital Association to survey hospital facilities and blueprint a coordinated national plan for the future development of hospital service. This Commission was an independent, nongovernmental committee, composed of outstanding leaders from many fields, both public and professional. On this Commission were appointed such individuals as Sarah G. Blanding, president of Vassar College; Dr. Evarts A. Graham, chairman of the department of surgery at Washington University School of Medicine;



Herbert Hoover, trustee of Stanford University; Charles F. Kettering of General Motors Corporation; Dr. Claude V. Munger, director of St. Luke's Hospital; and Matthew Voll, vice president of the American Federation of Labor. An immense amount of data has been collected, much valuable statistical information compiled, and a total of 181 recommendations submitted. The United States Public Health Service collaborated with the Commission in the project, each group arriving at its own conclusions and making its own recommendations.

The report of the Commission on Hospital Care shows a definite trend in this country for hospitals to become the center of all health activities. This trend is shown to be the result of advances in medical science and methods of treatment, in addition to the advantages to the community of lower costs and better medical and hospital facilities. The Commission recommends an integrated regional hospital system including both voluntary and government hospitals. The nucleus in each region would be the medical center, consisting of general and special hospitals grouped around a medical school. Large cities may have one or more such centers with smaller affiliated hospitals and so-called public health centers in outlying districts. The smaller cities will have general hospitals as the main medical center. Larger towns also may have a general hospital but in case such cannot be supported a public health center will be provided.

The report recommends providing office space for physicians in a hospital or in a building adjacent to it. Group practice is advocated with the hospital as the center since, in addition to office space, it can provide equipment and laboratory facilities.

There are many who will see in this report an opportunity for the hospital or health center to enter into the practice of medicine. A careful study of the report, however, seems to disclose no such intent. There is a fine line to be drawn here between the mere furnishing of facilities and the actual practice of medicine.

Of particular interest in connection with the provisions of the Hill-Burton bill are the recommendations that "it could be the purpose of federal aid to lift the level of hospital care in low-income states to a standard which should insure good health to the nation," and "a single state agency could have the responsibility for integrating hospital programs and for handling the allocation and distribution of state and federal funds to both governmental and voluntary hospitals within each state."

Special recommendations are made for the financing of the care of tuberculosis patients, of an expanded psychiatric service, and for the construction of special facilities for venereal diseases. The segregation of communicable diseases in separate hospitals is to be replaced by proper provisions for their care in general hospitals.

The two final chapters of the report deal with the legal basis for the operation of hospitals and the relationship of hospitals with governmental and voluntary health agencies.

The Commission is to be congratulated on its exhaustive study. The report presented in this volume merits careful consideration by both physician and layman.

*WHAT IS MANAGEMENT'S RESPONSIBILITY FOR THE MEDICAL CARE OF ITS EMPLOYEES?* A Radio Discussion by *Edward Holmblad, Franklin McLean, and John Wittmer*. Introduction by *Joseph Chivers* and *Leo Price*. University of Chicago Round Table, April 14, 1946.

Reviewed by ALBERT S. GRAY

Dr. Price, medical director of the Union Health Center of the Ladies Garment Workers, describes an industrial medical program with complete medical care for workers and cash disability indemnities. The plan is paid for by management and conducted by labor.

Dr. Chivers, medical director of the Crane Company, describes another plan, in which medical, surgical, nursing and hospital care are provided only for *compensable* accident and illness cases. A preventive program is also carried on, including health examinations and environmental controls.

Dr. Wittmer, medical director of the Consolidated Edison Company of New York, points out that the main disagreement between Dr. Price and Dr. Chivers is in the extent to which management should provide medical care. Dr. Wittmer, along with Dr. Price, advocates full care. His company provides complete medical and dental care financed jointly by employees and management. He feels that where industry sticks to diagnosis and advises an employee to get medical attention, the worker often does not know where to get help, fears the cost, and procrastinates with serious results.

Dr. Holmblad, managing director of the American Association of Industrial Physicians and Surgeons, brings out four points of agreement among medical men on management's responsibility for the medical care of employees: Full medical and hospital care should be given in workmen's compensation and occupational disease cases; in localities where there are no or insufficient medical facilities, then management should provide all necessary care; a confidential patient-physician relationship must be maintained at all times; and, because of this reason, the industrial physician should be responsible only to the chief executive officer of an organization.

In speaking of trends in industrial medicine, Dr. McLean, professor of pathological physiology at the University of Chicago, mentions a growing concern respecting industrial toxicology, prepayment health insurance, and the recognition of management's influence on workers' morale. Other trends noted are more effective health programs with stress on tuberculosis surveys, venereal disease control, eye conservation, and nutrition; wider health educational work; and increased facilities for special training in industrial medicine.

Dr. Holmblad discussed the importance of various special training and the educational trends in the field of industrial medicine and surgery. Courses are being added in undergraduate schools and to the curriculum of graduate schools, and contemplated plans envision a course of several years including hospital basic training.

To get back to the question of "What is Management's Responsibility for the Medical Care of its Employees?", the speakers argue that management has a moral and legal

responsibility for health problems arising out of employment. Mutual advantages to employer and employee of wider medical coverage are also recognized. The question of difference in ability to provide medical programs as between large and small plants is not discussed. It is only inferred in Dr. Wittmer's statement: "The average concern should operate very definitely on a preventive scale and do as much health teaching as it possibly can, particularly from a prevention standpoint."

**EXPERIENCES WITH FOLIC ACID.** By Tom D. Spies, M.D., Associate Professor of Medicine, University of Cincinnati School of Medicine, Director of the Nutrition Clinic, Hillman Hospital, Birmingham, Alabama. *Chicago, Illinois: The Year Book Publishers, Inc.* 1947. 110 pp. \$3.75.

Reviewed by WILMOT C. TOWNSEND

Dr. Spies previously reported the biological studies which resulted in the isolation and synthesis of folic acid. In this monograph he records his carefully controlled clinical experiments with this potent anti-anemic substance.

A striking response was obtained, similar in all respects to that which follows the administration of a potent liver extract. Like liver extract, it is effective in the macrocytic anemias of faulty nutritional states, as pellagra; sprue, either tropical or nontropical; macrocytic anemias of pregnancy, and Addisonian pernicious anemia. In addition a few cases of nutritional leucopena were benefited, and an occasional case of a macrocytic anemia, associated with liver disease, responded in typical form. The microcytic anemias, or any anemia due to a definite cause, showed no response either hematologically or clinically.

The dosage varied, but as a rule 5 to 10 mg. daily, either parenterally or by mouth, was an effective amount. In common with other workers, he found that folic acid did not improve the neurological changes associated with pernicious anemia, or prevent their occurrence. Therefore in this disease folic acid is not advised as a substitute for liver extract, except in those patients who are sensitive to the parenteral administration of liver. However, Dr. Spies never observed the development of neurological complications in the nutritional anemias under treatment with folic acid. In fact, he felt that a better clinical response was obtained with folic acid in the treatment of sprue than with liver extract.

Dr. Castle did much to clarify the etiology of these macrocytic anemias. It has been definitely proven that folic acid is not concerned with the intrinsic factors. Since purified liver extract contains infinitesimal amounts of folic acid, it is not a part of the erythrocyte maturation factor. Dr. Spies postulates that it is a hormone, and that it is concerned with the biological enzymic reactions of the body.

This monograph gives the results of the clinical studies done by Dr. Spies and his associates since the discovery of folic acid up to the present. He has proven that it is a potent anti-anemic drug, and he has listed some of its advantages and disadvantages. Because folic acid is such a new substance, many questions have been left unanswered and it is recommended that the practitioner wait for further

developments so that he can obtain a clearer conception of its action and use.

**REHABILITATION THROUGH BETTER NUTRITION—University of Cincinnati Studies in Nutrition at the Hillman Hospital, Birmingham, Alabama.** By Tom D. Spies, M.D., from the Department of Internal Medicine, University of Cincinnati College of Medicine. *Philadelphia and London: W. B. Saunders Company.* 1947. 94 pp., 50 Fig. \$4.

Reviewed by FREDERICK L. NICHOLS

In this monograph Dr. Spies describes the study of 893 cases of nutritive failure at the Birmingham Nutrition Clinic. The patients were carefully selected as cases who were severely debilitated, due primarily to nutritive failure.

As a result of this careful study in diagnosis and therapy, he emphasizes that these patients usually have a mixture of deficiency diseases. He stresses the importance of accurate diagnosis and states that prolonged, complete therapy beyond disappearance of symptoms is necessary for full rehabilitation.

He presents in detail the clinical syndromes of the various deficiencies except Vitamin K and D. Extensive tables and graphs indicate the incidence of presenting signs and symptoms taken from his clinical material.

The book contains an exposition of practical therapeutics for improved nutrition developed on a scientific basis. It provides a basic pattern in principles and details of therapy in nutritive failure.

This monograph presents graphic examples of the dramatic results which have been obtained with the diagnostic and therapeutic measures described. It is a comprehensive reference in this field for student, general practitioner and internist, with a large bibliography at the close.

**THE EGO AND THE MECHANISMS OF DEFENCE.** By Anna Freud. Translated from the German by Cecil Baines. *New York, New York: International Universities Press, Inc.* 1946. 196 pp. \$4.

Reviewed by Mildred H. January

This is the first American edition of a justly well known book, first published in English translation in 1937 as No. 30 of the International Psychoanalytic Library. It represents one of the most important contributions to the understanding of psychoanalytic psychology, distinguished by its clarity and, if one may use the word about a scientific work, its readability.

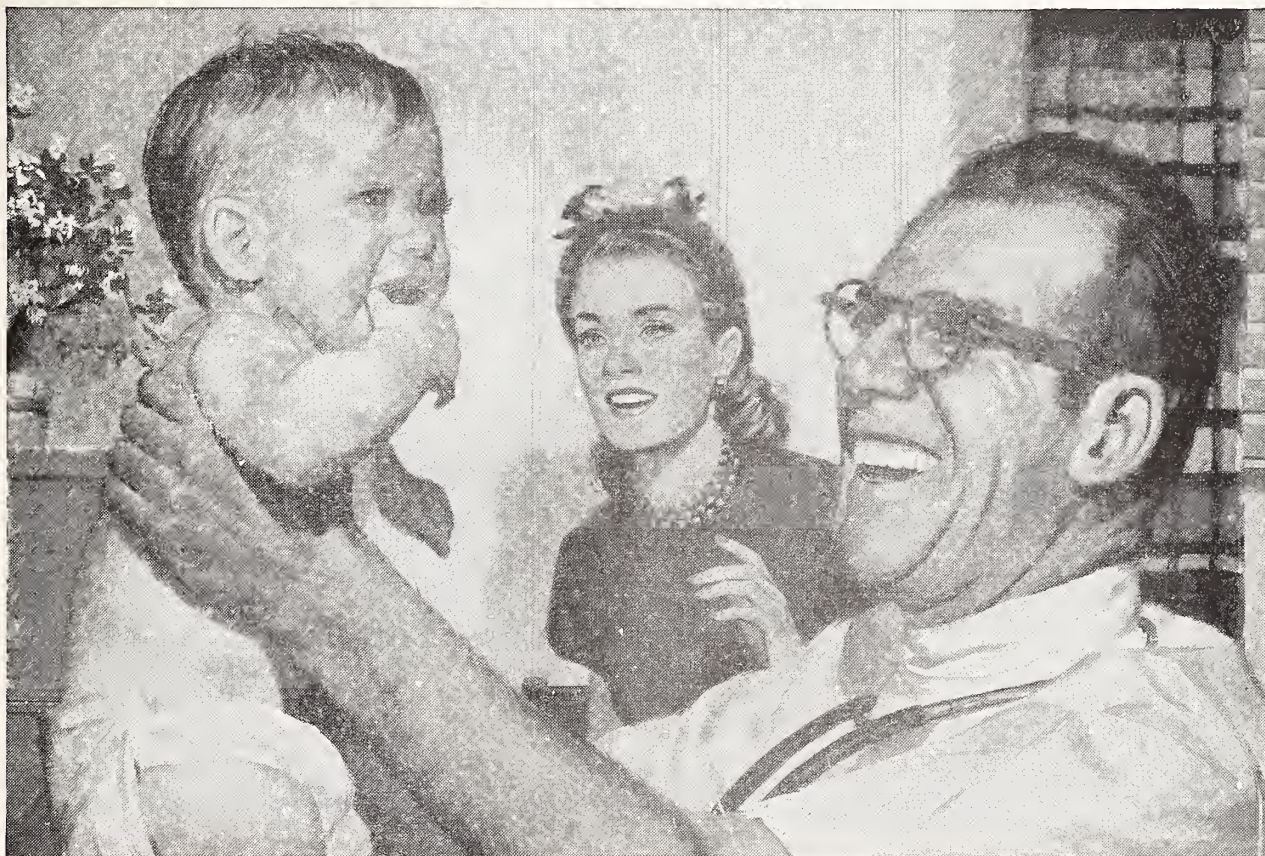
Psychoanalysis as a therapeutic method according to Anna Freud, has always been concerned with the ego and its abnormalities, that is, with that part of the personality which is in contact with reality and which is able to restrict undesirable impulses according to moral or ethical standards. Any investigation of more inaccessible parts of the personality is only a means directed toward "the correction of these abnormalities and the restoration of the ego to its integrity." Because the ego controls the other parts of the personality, it follows that all measures undertaken to limit unwelcome desires are done so by the ego, whether consciously or un-



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consciously. These protective measures are called, both by Anna Freud and other analysts, defences, a name first given to the general reaction by Sigmund Freud in 1894, later abandoned by him but reemployed in 1926.

During the early chapters, Anna Freud discusses the theoretical background of the production and meaning of defence mechanisms and enumerates many specific patterns of defence. The later chapters describe the reasons that force the ego to build defences in order to protect itself against the discomfort of anxiety. Anxiety may arise from three sources: (1) external or objective, (2) internal, from the super-ego or conscience, and (3) internal, from the strength of the instincts themselves. Different defences are characteristic of different periods in the development of the personality and of the ego, becoming more complicated as the personality becomes more integrated. A given defence may even be considered normal for one period of development but if used in a later period it may constitute a sign of abnormality.

The American edition is an exact reproduction of the English edition. Received with enthusiasm from the time of its first publication, Anna Freud's book has often been described as a "classic" in psychoanalytic therapy and practice.

**GYNECOLOGY WITH A SECTION ON FEMALE UROLOGY.** (Second Edition.) By Lawrence R. Wharton, PH.D., M.D., Assistant Professor of Gynecology, The Johns Hopkins Medical School; Assistant Attending Gynecologist, The Johns Hopkins Hospital; Consultant in Gynecology, The Union Memorial Hospital, Hospital for the Women of Maryland, Sinai Hospital and Church Home and Infirmary. 1027 pages with 479 illustrations. Philadelphia and London: W. B. Saunders Company. 1947. \$10.00.

Reviewed by STANLEY B. WELD

The unconventional type of text book is always interesting. Apparently the author in this case has had the medical student foremost in his mind as evidenced by the outline of the contents which appears at the beginning of each chapter. There are excellent discussions of female anatomy and embryology and the clinical features and disorders of ovulation and ovarian function are dealt with in a comprehensive manner. The chapter on the sympathetic nervous system may be commended for its clarity and excellent cuts, many of the latter being the author's and not reproduced from other sources.

The author reveals his training in urology as well as in gynecology by devoting about one-fourth of the volume to female urology. This section includes a chapter on Water, Cystoscopy by Dr. Charles L. Prince of John Hopkins Hospital and Medical School. There is an excellent chapter on the Urinary Tract During Pregnancy, and detailed discussion of the methods of examination of the urinary tract using the Kelly cystoscope with the patient in the knee-chest position. All gynecologists should be familiar with this technique.

Part of the unusual character of this volume is shown in the emphasis on certain operations to the exclusion of others equally or more important. For example, suspension opera-



ions are afforded a comparatively lengthy discussion, whereas the repair of vesicovaginal fistula occupies but a few lines. There is no detailed operative guide for vulvectomy or malignancy. The preoperative diagnostic finding of a watery discharge from the uterus in carcinoma of the fallopian tube is not mentioned and nothing is said of the use of testosterone preoperatively in reducing the magnitude of the lesions in pelvic endometriosis. The use of irradiation therapy for some unknown reason is included in the section on Ureteral Implantation and Chemotherapy.

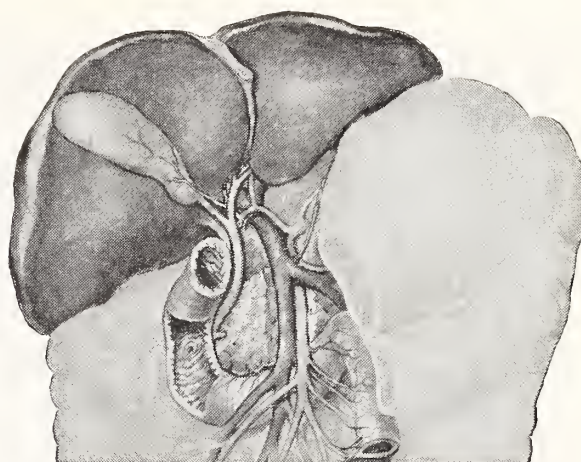
Without doubt it is unfair to pick flaws in a volume as excellent as this one. The gynecological surgeon can look elsewhere for operative techniques. It is refreshing to find an author who has the courage to state that "the proper treatment (of threatened abortion) is complete and continued rest in bed until every sign and symptom disappears," and "there has been a growing tendency to limit therapy designed to prevent abortion." Every gynecologist should read the excellent chapter on Normal Hygiene of Healthy Women.

Dr. Wharton is to be commended for his emphasis on established principles and for bringing to the attention of the gynecologist so much of value from the related field of urology.

**ADVANCES IN INTERNAL MEDICINE, VOLUME II.**  
*Editors, William Dock, M.D., Long Island College of Medicine, Brooklyn, N. Y.; I. Snapper, M.D., The Mount Sinai Hospital, New York, N. Y. Associate Editors, Tinsley R. Harrison, M.D., Southwestern Medical College, Dallas, Texas; Chester S. Keefer, M.D., Evans Memorial and Massachusetts Memorial Hospitals, Boston, Mass.; Warfield T. Longscope, M.D., Cornhill Farm, Lee, Mass.; George R. Minot, M.D., Thorndike Memorial Laboratory, Boston City Hospital, Boston, Mass.; J. Murray Steele, M.D., Goldwater Memorial Hospital, New York University Division, Welfare Island, N. Y. New York: Interscience Publishers, Inc. 1947. 642 pp. \$9.50.*

Reviewed by WILSON FITCH SMITH

During the recent years the scientific efforts of the world have been directed to the ends of waging war. There were, nevertheless, many spectacular advances in the field of internal medicine. Unfortunately most doctors were unable to keep abreast of these newer developments in their profession, either because they were serving with the armed services where opportunity for study and scientific reading were limited, or else because they were so overwhelmed by the load of civilian practice which they were carrying in the absence of their colleagues that they had little time for keeping up with the current trends in medicine. During the months that followed the return of doctors to civilian life there resulted a demand for refresher courses greater than has ever been met before. Excellent programs of postgraduate study have been established by the American College of Physicians and by individual teaching centers, but there still are many physicians who either have not been fortunate enough to be able to get away for one of these courses, or else have not been completely satisfied by the amount that they could learn in a course limited to a few weeks. "Advances in Internal Medicine, Vol. 2" comes as a much needed answer to the problem of acquainting internists, other specialists and general practitioners with the outstanding recent advances in internal medicine and related fields.



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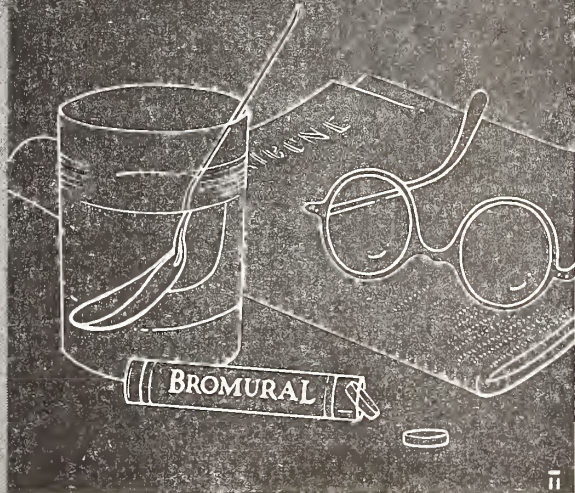
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This volume is in reality a collection of 13 monographs by well chosen authorities in various specialty fields of internal medicine. The first three deal with the most modern methods of diagnosis in cardiology. The chapter by Wilson, Rosenbaum and Johnston on the "Ventricular Complex of the Electrocardiogram" is by nature technical, but with the liberal use of diagrams and illustrative electrocardiograms it teaches the interpretation of variations in the limb leads and the newer precordial leads and explains the reasons for many of these changes by comparing the diphasic clinical curves with the monophasic curves of the experimental laboratory. In the next chapter John McMichael of London discusses the fascinating "Study of Circulatory Failure by Venous Catheterization." This new and dramatic approach to the study of cardiac dynamics has overthrown many long accepted theories and offers promise of answering long unanswered questions. In this chapter the present status of these studies is presented. The third chapter on modern diagnostic measures in cardiology is Sussman and Grishman's "A Discussion of Angiocardiography and Angiography." 49 splendid illustrations help to make this a most readable treatise and clearly indicate the great possibilities of this method.

There then follow two chapters that deal with surgical treatment of two internal medicine's biggest problems: hypertension and chronic pulmonary disease. Every internist should be well acquainted with the surgical measures that are available to combat these two large causes of disability. Keith S. Grimson in "The Surgical Treatment of Hypertension" discusses the various methods that have been used

and outlines the indications and contraindications for sympathectomy. John W. Strieder in his chapter on the "Surgical Treatment of Tumors and Chronic Inflammation of the Lung" shows how modern thoracic surgery has advanced in the conquest of lung cancer and chronic infection—conditions that only a few years ago were considered incurable.

There next are included two chapters that are direct outgrowths of research studies during the past war on subjects vital in modern warfare, but also with great peacetime application. "Progress in the Development of Insecticides for the Prevention of Insect-Borne Diseases" by James S. Simmons, and "Physiologic and Medical Aspects of Aviation and Deep Sea Diving" by A. R. Behnke are small text books on these subjects.

The discovery of penicillin as an antibiotic was one of the most important advances coming out of the war years. It has revolutionized the treatment of infections and has had far reaching influence in many fields of medicine and surgery. There are two fine chapters on the use of this agent. George Baehr and Isadore E. Gerber discuss "Penicillin Treatment of Subacute Bacterial Endocarditis" in considerable detail; while the chapter on "Use of Penicillin in Infections Other Than Bacterial Endocarditis" is well covered by Maxwell Finland. This chapter also includes a 23 page classified bibliography on penicillin that readily shows further references to any particular detail of this vast subject.

Two chapters covering important recent discoveries in blood follow. "The Problem of the Rhesus Antigen in Medicine" is carefully handled by Alexander S. Wiener, who has added much to our knowledge of this amazing phenomenon.



L. S. P. Davidson and L. J. Davis of Scotland have included in their chapter, "Pernicious Anemia and Other Megaloblastic Anemias," discussion of the modern diagnostic methods and an addendum covering the use of folic acid.

The final two chapters are concerned with the role of nutrition in disease. The war caused many worldwide deficiency states of varying severity and a number of our present problems in internal medicine are on nutritional basis, so that the chapter on "Nutritional Requirements in Disease" by MacBryde and Elman and the one on "Nutrition and Nutritional Diseases in the Orient" by I. Snapper are of great interest.

Because of the completeness with which each subject is dealt, the good indices, and the splendid bibliographies that accompany each chapter, this book is valuable as a convenient

reference source as well as a help to those who want to be briefed in "Advances in Internal Medicine."

*A HISTORY OF THE AMERICAN MEDICAL ASSOCIATION, 1847-1947.* By Morris Fishbein, M.D., with the Biographies of the Presidents of the Association by Walter L. Bierring M.D., and with Histories of the Publications, Councils, Bureaus, and Other Official Bodies. Philadelphia and London: W. B. Saunders Company. 1947. 1,226 pp. \$10.00.

Reviewed by STANLEY B. WELD

To Morris Fishbein is due the appreciation of every physician in the United States for completing a task of which each must be justly proud. Although this history was authorized by the Board of Trustees in 1929 and Dr. Fishbein had been collecting material over the intervening years, it was only toward the close of World War II that the actual preparation was begun.

As one reads the record from the founding of the American Medical Association to the present one is impressed by the contributions made by Nathan Smith Davis and George H. Simmons. To Dr. Smith must go the credit, not only for conceiving the American Medical Association as an organization, but also for pushing through to completion the work necessary to accomplish this organization. Not content with this, he gave unselfishly of his years in serving the organization as president, trustee, and in many other capacities. Dr. Simmons for twenty-five years devoted his entire time to the Association. First as editor and later as editor and general manager, as Dr. Fishbein says, "unquestionably he was the greatest factor in his generation in the development of the American Medical Association."

One is also impressed by the masterly way in which the editor of the History has gleaned from all the source material the valuable and presented it in such a manner as to be interesting. It is not an easy task to scan page after page of transactions of the House of Delegates and reports of the Board of Trustees, the Judicial Council, and all the other councils and committees and select from these the important. To present this data in readable form is an art.

Connecticut physicians will be gratified to read, not only of the part Jonathan Knight and Eli Ives played in the founding of the American Medical Association, but also the biography of each as seventh and fourteenth president, respectively, of the Association. Walter L. Bierring, himself a past president of the American Medical Association, has contributed to the volume a short and interesting biography of all the 101 presidents except himself. There is a lengthier biography of Nathan Smith Davis by a grandson, also a brief biography of each of the recipients of the Distinguished Service Medal since the first award in 1938.

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The Councils and Bureaus as well as each publication of the American Medical Association are represented in this volume by suitable historical accounts written by various authors. The libel suits of the American Medical Association are recounted by the editor, also the famous case of United States of America vs. the American Medical Association. In the Appendices may be found a list of the sessions and presidents of the Association, the Board of Trustees, data relating to the Council on Medical Education and Hospitals, the attendance record at each session of the Association, and the list of members of the Judicial Council.

Among the more recent contributors to the life of the Association have been Will C. Braun and Olin West. The former served in the Business Department of the Association for fifty-four years. Dr. West gave unstintingly of his energy over a period of twenty-four years, the majority of this period as secretary and general manager.

It is easy to be critical in an age when nothing seems sufficiently valuable or sacred to escape the probes of the investigator or even the bombs of the enemy. The American Medical Association has not been immune to all sorts of attacks, even from within its own ranks. Much of this, unfortunately, has been the result of ignorance. There is nothing like history to produce humility. "The History of the American Medical Association" at the end of its first 100 years will well repay the reader the time invested. The lessons to be found within its covers are invaluable.

**THE AMERICAN ILLUSTRATED MEDICAL DICTIONARY**—A complete dictionary of the terms used in Medicine, Surgery, Dentistry, Pharmacy, Chemistry, Nursing, Veterinary Science, Biology, Medical Biography, etc.; with Pronunciation, Derivation and Definition. (21st Edition.) By W. A. Newman Dorland, A.M., M.D., F.A.C.S., Lieut. Col., M.R.C., U.S. Army; Member Committee on Nomenclature and Classification of Diseases of the A.M.A.; Editor of "American Pocket Medical Dictionary." With the Collaboration of E. C. L. Miller, M.D., Medical College of Virginia. Philadelphia and London: W. B. Saunders Company. 1660 pages; with 880 illustrations, including 233 portraits. 1947. \$8.00 Without Thumb Index; \$8.50 With the Thumb Index.

Reviewed by STANLEY B. WELD

Beginning in 1900 this medical dictionary has appeared every two or three years until it has now reached its 21st edition. The war years have added much to medical terminology. These additions are covered as completely as possible in this latest edition. They include many new terms in the specialties of tropical medicine, aviation medicine, medical zoology and mycology, biochemistry and pharmacology with antibiotics, enzymes, vitamins and endocrines, and physics and nucleonics including the medical application of radioactive isotopes of the chemical elements.

As in previous editions there are included tables of weights and measures and a table of doses in both apothecaries' and metric systems. The flexible covers and binding, the use of the large page with a compact but clear typography, and the alphabetical thumb index make the volume attractive and convenient.

## DERMATOLOGIC CLUES TO INTERNAL DISEASE.

By Howard T. Behrman, M.D., Assistant Clinical Professor of Dermatology, New York University College of Medicine; Adjunct Dermatologist, Mount Sinai Hospital and Beth Israel Hospital; Associate Dermatologist, Hillside Hospital; Diplomate of the American Board of Dermatology and Syphilology; Fellow of the American Academy of Dermatology and Syphilology. New York: Grune & Stratton. 1947. 165 pp. 118 illustrations.

Reviewed by F. EARL KUNKEL

The author attempts to correlate manifestations of skin disorders with those arising in some visceral dysfunction.

The subject matter is presented in the form of concise descriptions of constitutional diseases exhibiting associated cutaneous lesions. The descriptions are listed alphabetically and briefly. There is no discussion of the histopathology of the diseases discussed, of treatment or of references to original publications. This is a small book and is as the title implies, clues, and not a textbook. However, a large number of facts are presented which have frequently been confirmed and demonstrated. The brevity perhaps might mislead some physicians to underestimate the numerous fundamental facts presented.

This edition should enjoy some popularity because there is room for a small book dealing solely with dermatologic clues to internal disease.

## TWENTIETH ANNIVERSARY YEAR OF HAROFE HAIVRI

### The Hebrew Medical Journal

The attention of the medical profession is directed to the appearance of the Spring issue of *Harofe Haivri* (The Hebrew Medical Journal), a semi-annual bilingual publication edited by Dr. Moses Einhorn. This issue, Volume I, 1947, inaugurates the 20th anniversary year, and in his editorial Dr. Einhorn discusses in detail the aims and growth of the Journal through the years.

In the medical section, the following subjects are offered: "The Clinical Use of Streptomycin" by Emanuel Appelbaum, M.D., "Anticoagulant Therapy in the Treatment of Thrombosis" by Shepard Shapiro, M.D., "Narcoanalysis and Narcosynthesis" by Leon Reznikoff, M.D. The section on Palestine and Health contains an enlightening statistical survey on the health of the young generation of Palestine, by Dr. A. Mundlak; also, Dr. M. Buchman writes at length on the historical and archaeological aspects of the Hot Springs of Tiberias.

Under the heading of Historical Medicine, Dr. Z. Muntner presents a treatise in which he discusses the classical pronouncements on medical ethics by Asaph the physician, who lived in the 9th century. In the section on Personalia Dr. Emanuel D. Friedman writes a memorial tribute to the memory of the late Dr. Isidore W. Held, discussing him as a physician, Jew, and as an American.

The original articles are summarized in English to make them available to those who are unable to read Hebrew. For further information, communicate with the editorial office of *The Hebrew Medical Journal*, 983 Park Avenue, New York 28, N. Y.



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*The*  
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MIDYEAR DINNER

Woman's Auxiliary

and

Connecticut State Medical Society

Thursday, December 4, 1947

Mrs. Robert Jay Cook, President of the Woman's Auxiliary, *presiding*

---

SPEAKERS

James R. Miller, M.D., President, Connecticut State Medical Society. Member of the Board of Trustees, American Medical Association

"A Prepaid Medical Service Plan for Connecticut"

Louis H. Bauer, M.D., Hempstead, Long Island. President, Medical Society of the State of New York. Chairman of the Executive Committee of the Board of Trustees, American Medical Association. Delegate from the United States to the World Medical Organization Conference in Paris

"The World Medical Organization"

NEW HAVEN LAWN CLUB

Social hour 6:30

Dinner 7:00

Places by reservation only. All members of the Society and members of the Auxiliary will receive reservation cards.

The House of Delegates of the Society will hold its semi-annual meeting on Thursday afternoon, December 4, at the New Haven Medical Association

MANAGEMENT OF THE COMPLICATIONS OF DIABETES

ELAINE P. RALLI, M.D., *New York*

The Author. *Associate Professor of Medicine, New York University College of Medicine*

IN CONSIDERING the question of the management of the complications of diabetes, it has seemed to me that it is both dull and confusing to itemize the various complications and then relate the methods of treating each one of these. There are certain basic considerations in the approach to the management of the complications that arise during the life of a diabetic individual and they can be discussed in one of several ways. For example, one can discuss the complications on the basis of those inherent in the diabetic state and of those resulting from the exigencies of living or (2) one can group the complications on the basis of their acuteness or their chronicity. A third avenue of approach to the discussion is to consider the complications on the basis of their physiological effects on the state of the diabetes. I have chosen the latter because it has seemed to me that by and large this provides the most reasonable basis for treatment and, furthermore, the treatment suggested on the basis of this approach has a definite pattern and can be applied, with slight modifications, to many situations with which the diabetic is faced. On this basis the complications seem to me to fall into three groups (Table I); first, the physiological disturbances which by increasing the severity of the diabetes increase the tendency to ketosis and also involve changes in water balance. You will quickly recognize the innumerable individual disturbances which can be grouped under this heading. They are, for example, all of the infections—either medical or surgical in nature—gastritis or enteritis causing nausea, vomiting, and dehydration, omission of insulin and dietary indiscretions. In the second group are the complications associated with degenerative lesions in the arteries, heart, kidneys, and extremities. With these degenerative lesions the diabetes is usually not aggravated although an exception to this is severe coronary thrombosis. The third group

might be, perhaps, better grouped as a subdivision of the first, because the diabetic state is rendered more severe. I refer to those disturbances in hormone balance which are associated with adolescence, with hyperthyroidism and, in the female, with the menses and with pregnancy. I have, however, considered them separately because they have an element of chronicity in that they affect the individual for months to several years and also because they merit attention due to a possible common etiology.

TABLE I  
GROUPING OF COMPLICATIONS

- I *Physiological Disturbances* which by greatly increasing the severity of the Diabetes result in dehydration and overproduction of ketone bodies.
- II *Degenerative Complications* involving the arteries and as a rule, not affecting the Diabetes.
- III Complications due to a disturbance in the inter-relationship of the internal secretions.

TABLE II  
MODERATE INCREASE IN SEVERITY OF DIABETIC STATE

TIME	APPROXIMATE				ACTUAL UNITS INS.
	CARBOHYDRATE	INSULIN	SUGAR	ACETONE	
8 A.M.	50 Gms	20	2%	2+	20
12	50 Gms	15	2%	1+	20
4	50 Gms	20	1%	0	15
8	50 Gms	15	1%	0	15
12	25 Gms	10	0	0	5
4	25 Gms	10	0	0	5

The basis of the management of the complications of the first group is to prevent or overcome ketonuria, to combat dehydration and to control glycosuria. This is done by (1) repeated injections of regular or crystalline insulin which insures the initiation of the carbohydrate cycle and thus prevents the overproduction of ketone bodies by the liver, (2) by the administration of sufficient amounts of carbohydrate so that this food stuff will be available as a source of energy and (3) by the administration of adequate amounts of fluid and NaCl in



order to rehydrate the individual and provide some additional base. Naturally, the use of the anti-biotic drugs to control the infective agent where infection is the cause of the disturbance is indicated. This treatment is demonstrated in the tables. In Table II the procedure is adjusted to conditions where vomiting is not a complication. The main points are to outline the treatment on a twenty-four hour basis, select the amounts of carbohydrate that you wish to give, decide on a schedule of insulin doses and prepare to modify these on the basis of the urine reports. Table III gives examples of feedings that may be used. There is no substitute for regular and frequent urine analyses for sugar and acetone. This, I think, has always been the stumbling block to the busy physician but if one has a definite method of approach and a schedule such as is shown here, there is much less confusion. Several other factors have contributed to facilitating the procedure—for example, in place of having to send the urine to a laboratory for analysis, there are now tablets which give a satisfactory test for sugar and which merely require a test tube, water, and the urine to be tested. Acetone tests may be done with

TABLE III			
EXAMPLES OF FEEDINGS CONTAINING 50 GRAMS OF CARBOHYDRATE AND PROTEINS AND FATS AS INDICATED			
Feeding No. 1	C 50 Gms	P 10 Gms	F 9 Gms
	Milk—1 glass (240 cc)		
	Toast—2 slices (60 Grams)		
	Jelly—2 teaspoons (10 Grams)		
Feeding No. 2	C 50 Gms	P 6 Gms	F 8 Gms
	Orange Juice—1 glass		
	Milk—6 ounces		
	Cereal—1 ounce		
Feeding No. 3	C 50 Gms	P 10 Gms	F 13 Gms
	Orange Juice—5 ounces		
	Toast—2 slices		
	Egg—one		
	Butter—one teaspoon		
	Milk—3 ounces		
	Coffee—1 cup		

no effort by using Rothera's mixture, which is a powder, and adding urine and a few drops of ammonium hydroxide. The nurse, the patient, or a member of the family can readily do the test at the times required and if the insulin doses are to be changed they can be done on the basis of the tests. By visualizing the treatment on a 24-hour basis the picture of what you propose to accomplish is clear and fragmentary treatment is avoided. As is shown in Table IV, this treatment is readily adjusted to an

increasingly severe derangement in the diabetic state. If vomiting ensues, fluids must, of course, be given by vein. These are continued until the vomiting has ceased and the dehydration is overcome and a schedule of feeding four or six times during the day is resumed. In severe cases plasma transfusions are necessary and should be given promptly.

TABLE IV  
INCREASED SEVERITY OF DIABETIC STATE, ASSOCIATED WITH VOMITING

On Admission:					
Infusion of 5% Glucose and Normal Saline 1 to 2 Litres					
Intramuscular injections of insulin as follows:					
TIME	URINE TESTS		INSULIN UNITS	STATE OF PATIENT	INFUSIONS
	VOL. CC	SUGAR ACETONE			
0	200	4% 2+	30-40	Nauseated	1000 CC
½ Hr	100	4% 2+	30		
½ Hr	200	4% 1	20		
½ Hr	100	2% 0	15		
1 Hr	250	1% 0	10		500 CC

Then change to fluids and carbohydrates by mouth, first at 2 hour intervals, then every 4 hours.

The degenerative complications do not, as a rule, severely disturb the diabetic state and management is directed primarily at their prevention. This is not a simple matter but one thing is certain, that proper control of the diabetes will help to prevent these complications. However, instruction as to the amounts of insulin is not enough. Prevention involves teaching the individual to lead a reasonable existence; to avoid fatigue and strain; to always eat an adequate diet; and to be checked periodically for signs of circulatory disturbances or degenerative diseases including the neuropathies. In one group of these complications, those affecting the extremities, we have found that foot exercises and care of the feet have significantly decreased the incidence of infections of the feet and of gangrene. In fact, we have a foot clinic in the Diabetic Clinic and the patients visit this regularly and are cared for by the podiatrists. As a result of proper foot care and exercises, the incidence of gangrene decreased and the number of patients requiring hospitalization for foot complications fell significantly. There is still much to be desired in the treatment of such complications, and as with all vascular lesions, once they are established, therapy is usually symptomatic and not satisfactory. This is equally true for the vascular lesions that affect the eyes, as also for the other eye complications. Retinopathy is a serious complication and can occur at an early age in the diabetic.

Dolger suggests that the eye lesion is the earliest manifestation of some diffuse vascular process—that it is not an isolated finding but is part of the peculiar vascular change occurring in certain types of diabetes. This point of view is quite generally shared now and some observers consider that changes in the capillaries and particularly in the veins are the probable causative factors in diabetic retinopathy. The general opinion is that some changes in the constituents of the blood are responsible for the changes in the vessels and that such changes may well be the starting point of the pathological process. Newer methods of therapy are directed against the possibilities that vitamin deficiencies or some endocrine disturbances are involved. Large supplements of certain vitamins are used in the therapy of these conditions. In particular vitamin A, because of its relation to the visual cycle, and vitamin C and P because of their effect on capillary fragility. Wald, in a very stimulating Harvey lecture (1946) on the Chemical Evolution of Vision has given evidence that in plants, as in animals, carotenoids play a major part in the photoreceptor process. He states that in vertebrate cones a new photosensitive pigment, iodopsin, is present. Indirect evidence suggests that it is a carotenoid pigment. There is, unfortunately, not time enough to go into the details of his work, but he concludes that cone vision, like that of the rods, depends upon vitamin A like substances in photoreception. We know that the metabolism of carotene and vitamin A depend on a normal functioning liver. In diabetes liver function may become disturbed if adequate amounts of protein are not included in the diet. This is reflected in the enlarged fatty liver which is less common now that carbohydrate is more liberal in the diet and that fat is restricted and protein is increased. The possibility exists, therefore, that some of the visual disturbances that plague the diabetic patient stem from the effects of metabolic disorders involving the liver. This brings us back to the point at which I began this part of the discussion, namely, that proper control of the diabetic patient by adequate diet, containing ample amounts of carbohydrate and protein, and the use of sufficient amounts of insulin, may serve to prevent some of the degenerative complications. Of interest also, in this connection, is the report of Rundles on diabetic neuropathy. He points out the association of this complication with lack of proper control of the diabetes *but* he emphasizes that this complication

as well as retinopathy and hepatomegaly are due to some, as yet, unexplained metabolic disturbance. I was interested also in a report by Barnard in 1943 in which he treated eight patients with diabetic retinosis with liver extract. The therapy had no effect on the visual acuity but the neuritis, which was present in five of the patients and which is often present in diabetic patients with retinosis, disappeared.

We have much to learn in this field of the disease and it *may* even be that the etiological factors in the degenerative lesions are due to profound disturbances in metabolism which may cause the diabetic state itself, as well as be responsible for the degenerative lesions.

The third group of complications can be traced more logically to a disturbance in the balance of the hormones from the various glands of internal secretion. Suggestion of such interrelation was made, many years ago, by Claude Bernard and the pattern has been developed by Houssay, Long, Lukens, and others. Recently, the concept of the action of insulin by the Coris and Dewitt Stetten, Jr. provides an explanation which, although incomplete, gives further evidence of the way in which the anterior pituitary operates in carbohydrate metabolism. I should like to discuss the basis of this action. As clearly presented by Stetten in the J.A.M.A. (1946), one must realize that glucose is inert unless it undergoes phosphorylation to glucose-6-phosphate, a process catalyzed by the enzyme *hexokinase*. Once glucose has been phosphorylated, many pathways are open to it, for example:

- 1—in the liver, glucose-6-phosphate may be split to regenerate glucose or
- 2—glucose-6-phosphate may be converted into glycogen, or
- 3—it may break down to pyruvate, lactate and other 3 carbon fragments, which
- 4—may be synthesized to fatty acids, or
- 5—may be burned to CO<sub>2</sub> and water.

These several fates of glucose are influenced by *the level of insulin in the body*. All the processes which are influenced by insulin have one common step—and that is the reaction catalyzed by hexokinase. The effect of insulin is on this reaction. The Coris have shown that anterior pituitary extract acted as a specific inhibitor of hexokinase and when this material was present in excess, phosphorylation of glucose to glucose-6-phosphate was retarded. In view of the experiments of Long, on the amelioration of diabetes after removal of the adren-



ls, the effect of adrenal cortical extract was also studied. By itself the adrenal extract had no effect but when added to A.P.E. it definitely increased the inhibitory action of the latter on hexokinase. Insulin, which likewise is without any direct action on hexokinase, serves to abolish the inhibiting action of anterior pituitary extract. Again, as pointed out by Stetten, this elaborate hormonal control of hexokinase activity can be predicted to lead to the following effects:

1—an excess of insulin would overcome the physiologic inhibition of the hexokinase reaction imparted by the A.P. inhibitor and in this case,

A—the phosphorylation of glucose would then proceed with undue rapidity;

B—the level of blood glucose would fall and all the reactions of glucose-6-phosphate would be enhanced which means, glycogenesis, lipogenesis, and combustion would be accelerated.

Whereas, if an excess of anterior pituitary inhibitor were present or if there was a physiologic decrease in insulin, which normally antagonizes this inhibitor, the hexokinase reaction would be impaired and then, blocked at this step,

A—the utilization of glucose would be slowed down;

B—glucose would continue to arise from its normal sources; therefore,

C—the concentration of blood glucose would increase and glucose would appear in the urine.

When this impairment of hexokinase activity occurs, glucose is no longer available as a starting material and other bodily constituents may be expected to contribute to the sequence. Thus the reserves of glycogen, fat and even tissue proteins are drawn on, liver glycogen falls and the rate of production of ketones increases and ketosis is on hand. Thus it would appear that the important action of insulin in the body is to release the enzyme hexokinase from its physiologic inhibition.

How can this be fitted into the handling of the complications occurring as evidences of endocrine imbalance? Actually the use of this knowledge helps one appreciate the character of the disturbance and makes it obvious that during periods of growth, in pregnancy and in hyperthyroidism . . . all instances when the anterior pituitary is likely to be hyperactive we can logically expect that much larger amounts of insulin will be needed. The severity of the diabetes varies in individuals but when

the above mentioned complications are occurring additional care of the patient is indicated. Where the child is concerned the parent should be warned that as he grows and reaches adolescence the diabetes will become more severe and during this time urine examinations should be done, not once but three or four times during the day. The amounts of insulin will not only increase but there is a tendency to ketosis and the diabetic state may vary considerably from month to month. This means frequent visits to the physician. Again this period can best be handled by working out a schedule of insulin dosages which are based on a daily regime. The daily basic amount of insulin is considered as both the amount and its distribution through the day, that keeps the individual reasonably sugar free. This usually means the use of regular and protamine insulin either mixed or given separately, before breakfast with perhaps a dose of regular or protamine before supper. With this as the basic dose the patient is advised to test the urine before meals and at bed time and to control the presence of glycosuria by additional amounts of regular insulin. This actually is not difficult and works out quite well and curiously enough if records are kept a pattern very soon becomes apparent. Additional care should be taken during this period of the child's life to avoid infection. He must receive a liberal diet as well as ample amounts of salt and fluid. Young people are apt to eat in a great hurry and gastric upsets should be avoided as they may cause considerable difficulty at this period of the diabetic's life.

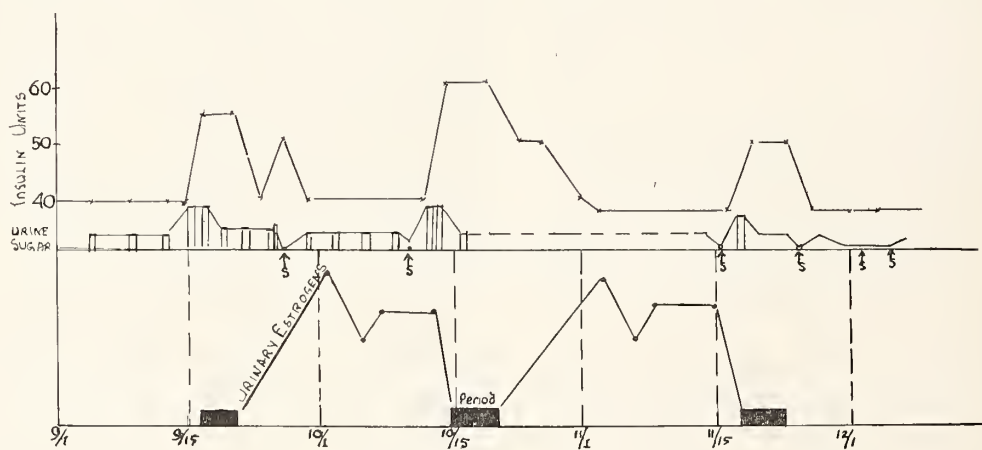
The management of the patient with hyperthyroidism is relatively simple, as the increased amount of insulin required is consistent and is usually an increase of about 35 per cent of the patient's usual dose. Naturally, with this complication, control of the hyperthyroid state is the important thing. In spite of the fact that there are now antithyroid drugs which can control the hyperthyroidism, for the diabetic patient at least, removal of the thyroid gland is the safest procedure. Following operation there is invariably a drop in the amount of insulin required.

The management of the pregnant diabetic patient is much the same as the management of the adolescent case. The basic regime requires modification and the diabetes must be carefully controlled. This means more frequent urine tests and careful supervision by the physician. The diabetes seems to be

the most difficult to control in the first and the third stages of pregnancy and both of these stages have outstanding difficulties. In the first stage vomiting and nausea make dieting sometimes difficult, and in the third state the diabetes is apt to become more severe and there is the problem of the delivery. The diet may have to be readjusted during the first stage of pregnancy and the insulin dose will vary accordingly. As for the delivery itself, it is wisest for the diabetic patient to be in the hospital before the actual time of delivery and the insulin can be readily adjusted and glycosuria controlled. Prior to delivery the patient should receive an infusion of 5 per cent glucose in normal saline and an intramuscular injection of insulin. The latter can easily be estimated by the urine test and with the further knowledge of the amounts the patient has required for control. Following delivery the infusion may be repeated or not, depending on the severity of the diabetes. Insulin should be given in much smaller doses, and most patients will only require a third of the daily amount for several days after delivery. One may infer that the inhibitor of hexokinase is absent and so the phosphorylation of glucose is proceeding at an accelerated pace. We had one diabetic who,

carbohydrate and about 65 grams of protein. The fat is kept low. The diabetes is kept well controlled. Therapy with estrogens or with stilbestrol has not been routinely instituted. There is, as you know, considerable discussion as to the question of the role of hormonal imbalance in the etiology of the toxemias, particularly in the diabetic. I think it fair to say that the observations that have been published need confirmation and I am confident that as the methods of determining the various hormones in the urine improve, we will be in a better position to know the nature of the disturbances that result in fetal deaths and cause premature delivery.

Another complication that falls into the group of hormone imbalance is the occasional effect of menstruation on the severity of the diabetes. This fortunately is not a common occurrence but when it is present may cause a sharp increase in the severity of the diabetes. In Figure 1 is charted the relation of the insulin requirement to the onset of the menstrual period in a young female patient in the clinic. Glycosuria and ketonuria occurred with absolute regularity in the patient on the third or fourth day before the onset of the period. In fact the patient was often admitted to the hospital for therapy of



INSULIN REQUIREMENT IN A 24yr OLD DIABETIC AND EFFECT OF MENSTRUAL CYCLE  
Dr. M.C.

following delivery, required no insulin for seven days!

As for the management of complications occurring in pregnancy in the diabetic, that would require considerable time to discuss adequately. I can only give you a brief summary of what has seemed to us to be a logical procedure. The patient's diet should be carefully arranged and it must contain adequate amounts of carbohydrate and enough protein. We have used from 200 to 250 grams of

the ketosis. By charting the course and noting the amounts of insulin required at this time it was possible to forestall the severe glycosuria and the ketonuria. This is a composite chart made by Dr. Cohn, who took care of this patient in the clinic, and the estrogen excretion is based on reports in the literature and were not done on this particular patient. This gives you an idea of the relation of the menstrual cycle to the state of the diabetes in this patient. There is no adequate explanation at



present as to the mechanism of this effect but we might infer that the inhibitory action of the anterior pituitary is increased by virtue of this hormonal disturbance. Increased amounts of insulin serve to overcome this inhibition.

This discussion is far from adequate but I hope it has served to orient your point of view in regard to the management of the complications of diabetes. In short, as I began, by pointing out that these complications have a physiological basis and that by appreciating the fundamental disturbance one is better able to visualize and plan the therapy. Furthermore, the causes of the complications offer a rationale for their treatment. They do more than this . . . they offer to us as physicians an expanding opportunity for the study of disturbances of metabolism. The complications associated with the diabetic state have provided clues as to the nature of some of the fundamental metabolic

processes in the body. Twenty-five years ago, when insulin was discovered, one might have reasonably thought that the answer to the etiology as well as to the treatment of diabetes had come. This as we now realize, is far from being the case and daily this disease is providing new opportunities to the investigator and the student of medicine for further study of the intricate disturbances in the biochemistry of the body. Every physician becomes a part of this developing research as he studies and records what happens to the diabetic patient under his care.

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## ACUTE APPENDICITIS IN MYELOGENOUS LEUKEMIA—A CASE REPORT

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Dr. Nolan. *Resident in Surgery, St. Francis Hospital.*

THE FOLLOWING case is reported because the occurrence of a rather common disease during the course of one of the blood dyscrasias is rather unique and raises one or two points in management.

## HISTORY

T. R., a fourteen year old American boy was admitted to the hospital on April 9, 1947 from the Tumor Clinic with a chief complaint of abdominal pain of twelve hours' duration. The pain had commenced the night before entry and had been situated in the lower abdomen, was steady in character, was followed by some nausea and retching, and permitted only fitful sleeping during the night. Early in the morning the pain shifted to the right lower quadrant, became more severe, and the patient was unable to eat breakfast.

The patient was originally admitted to this hospital on December 19 for suturing of a severe scalp laceration and a routine blood count disclosed a moderate secondary anemia and a white count of

146,000 with a differential of 66 neutrophils, 4 lymphocytes, 5 eosinophiles, 4 basophiles, 1 myelocyte, 13 metamyelocytes, 1 promyelocyte, 1 myeloblast and 5 "smudge" cells. He was discharged for the holidays after one transfusion and was next seen in the Tumor Clinic on January 3, 1947 at which time the spleen was found 5 cm. below the costal margin. 315 roentgens were given to the splenic area in the next few days and the patient was next admitted on January 22 for transfusion and further study.

Discharged after five days the patient was then followed in the Tumor Clinic for the next two months. Blood counts at the various visits are charted, (Figure 1) and the only pertinent points of interest between January 27 and the day of entry were the palpation of a left axillary node on March 12 and the failure to palpate the spleen on the same date.

Physical examination on entry disclosed a well developed, well nourished boy who looked sick and

FIGURE 1

DATE	HEMOGLOBIN (%)	RBC (MILLIONS)	TOTAL LEUCOCYTES	NEUTROPHILES	LYMPHOCYTES	MONOCYTES	EOSINOPHILES	BASOPHILES	MYELOCYTES	METAMYELOCYTES	PROMYELOCYTES	SMUDGE CELLS	MYELOBLASTS
December 20, 1946	59	2.9	146,000	65	3		4	1	7	16	4		
December 27, 1946	72	4.0	150,000	66	4		5	4	1	13	1	5	1
January 13, 1947	60		166,000										
January 22, 1947	67	3.4	79,600	49	4			3	6	28	10		
January 27, 1947	80		62,700	66	4	1		2	4	19	4		
February 12, 1947	80	4.0	11,700										
March 12, 1947	80		27,900										
April 2, 1947	69	3.8	13,200	64	11	3	6	4	1	2	4	5	
April 9, 1947	74	3.8	29,200	92		4		1		3			Operation
April 10, 1947			40,000										1st P.O.
April 11, 1947			33,000	86	2	2		1	2	4		3	2nd P.O.
April 12, 1947			24,400	81	5	4		2	3	5			3rd P.O.
April 14, 1947			20,800	84	5	1	2	4	2	2			5th P.O.
April 15, 1947	76		26,000	78	7		2	5	2	1	5		6th P.O.
April 16, 1947			25,800	76	7	1	2	2	6	4	2		7th P.O.
April 17, 1947			21,000	79	8	1	4		4	1	3		8th P.O.
April 21, 1947	72	3.8	18,600	76	8		3	5	5	2	1		12th P.O.
April 23, 1947			17,600	76	8		2	4	6	2	2		14th P.O.
May 7, 1947	82		19,700	71	8	1	3	1	4	9	3		O.P.D.

in pain. Temperature was 99.8 (rectal), pulse 80 and respirations 20. A few small nodes were again palpated in the left axilla. Examination of the abdomen disclosed definite tenderness in the right lower quadrant and some muscle guarding. There was no rigidity nor rebound. Rectal examination disclosed exquisite tenderness on the right side and only minimal on the left.

The white count was 29,200 with a differential of 92 neutrophiles, 4 monocytes, 1 basophile and 3 metamyelocytes. This was compared with the blood counts of April 2 and the previous weeks and the striking change in the percentage of neutrophiles was noted and accepted as corroborative proof of the clinical diagnosis of acute appendicitis. More weight was attached to this point than to the definite elevation of the total leucocyte count. The urine was negative.

The patient was prepared for operation and the bleeding and clotting times were found to be one and three minutes respectively. A check of the blood smear showed the platelets to be "adequate."

An acute suppurative appendicitis was found at operation and the appendix was removed through a right rectus muscle retracting incision and the abdomen was closed in layers. At operation the mesenteric nodes were found to be of average size and the

spleen was palpated for but lay above the costal margin and this was taken as evidence of return to normal size.

The postoperative course was uneventful but the blood counts were followed closely and show an interesting pattern during the convalescent period, (Figure 1). The patient got up on the fourth day and sutures were removed on the ninth day. He was discharged on the fifteenth day and follow-up, one month after operation, found the patient well except for his primary disease of myelogenous leukemia.

REMARKS

While numerous other acute infections and contagious diseases have been reported occurring at the onset, during the course or being a contributory cause of death in leukemias, appendicitis has not been reported.<sup>1</sup> This case has been presented because of the interesting changes in the white count, the definite shift to the left in the Schilling index with the onset of the disease and the very gradual return to the levels of the previous counts. In this case the surgeon was able to use his most reliable laboratory procedure despite the abnormally high count of the leukemic patient to confirm his clinical decision. While hemorrhagic tendencies are seen during the course of leukemias and have a bad prognostic



significance,<sup>2</sup> its presence in this case in addition to the ultimate grave outlook might have meant surgical ruin due to uncontrollable bleeding. Any latent manifestation was easily ruled out by pre-operative bleeding and clotting times and examination of the platelets.

## SUMMARY

1. A case of acute appendicitis occurring in a patient with myelogenous leukemia is reported.

2. The effect of an acute suppurative process on the diseased hematopoietic system is shown in the chart (Figure 1).

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## TULAREMIA — A CASE REPORT

### Recovery With the Use of Streptomycin

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THE patient H. B. married, bricklayer, on December 11, 1945 killed, and skinned five rabbits. Four days later he had what he felt was a grippelike infection starting out with slight chill and aching sensation all over his body. This continued until the 19th when he sought medical attention. At that time it was pointed out to him that he had a small red sore on the middle finger of the right hand. Coming up from that sore was a red streak going up into the forearm causing a slight enlargement of right epitrochlea gland and there was a large swelling of his axillary gland in the right side. There were no other glands swollen in the body. Diagnosis was made of lymphangitis and patient was treated with hot soaks and sulfadiazine given, one gram every four hours for four days. On the fourth day he began passing bloody urine and sulfadiazine was discontinued. He was then put on calcium penicillin by mouth and was given a total of 500,000 units over a period of four days. All during this time his temperature was around 99 degrees in the morning and between 102 and 103 degrees in the evening. It was accompanied by sweats.

On December 27 a diagnosis of tularemia was suspected and a blood specimen sent to the State Department of Health was returned, the test positive in all dilutions. Inasmuch as his general condition was good and he had passed the first two weeks of his illness, it was felt that his condition would progress satisfactorily and no further attempts at specific therapy were tried. Temperature kept on

with afternoon rise until January 9 when it was normal both morning and afternoon. The next day he complained of a little pain in his right chest and a slight cough. He was put back on sulfadiazine and within twenty-four hours he began having hematuria and it was discontinued. The temperature went higher, to 104 degrees, the general condition became worse, the patient became disoriented and was advised to come into the hospital for more specific therapy.

He entered the hospital on January 15, 1947 at which time examination showed the following: general appearance—well developed, slightly pale, debilitated, with slight dyspnea. Temperature 104 degrees, pulse 140, respirations 26. Nutrition, poor, vitamin B and C deficiency? Blood pressure 120/70. Head: negative, no obvious malformation; cheeks slightly sunken. Eyes: negative, conjunctivae slightly pale, sclerae clear, pupils round, equal and react to light and accommodation.

ENT: slight nasal septum deviation to right, slight injection of posterior pharynx with redness of uvula and faucial pillars; slight post nasal drip; no ulcerations; coarse tremor of tongue.

Mouth: partial edentia; tongue dry with moderate beefy redness and accentuation of papillae; gums—bleeding with compression; no cyanosis. Neck: one or two shotty anterior cervical nodes on right; deviation of trachea to right, otherwise negative. Chest: moderately large, nodular axillary mass on right; breathing shallow, rapid (30/min.) with splinting of right side posteriorly. Lungs:

dullness to flatness over right side posteriorly especially at right base with decreased breath sounds and medium, moist, inspiratory rales and bronchovesicular breathing at right base; decreased fremitus at right base. Heart: negative. Left border of dullness at mid clavicular line (9 cm. from mid sternal line) with normal aortic dullness and right border beneath sternum; regular sinus rhythm at accelerated rate (136/min.); no murmur heard; A2 equals P2.

Abdomen: slight distention with tympany throughout; no tenderness, spasm, liver edge smooth at one finger below right costal margin with corresponding dullness, ?? spleen just palpable at four fingers below left costal margin no palpable masses, no scars, no herniation.

Genito-urinary: external genitalia negative; no costal vertebral angle tenderness, negative Murphy's sign. Extremities: upper-small, scabbed, healing ulcers on dorsum of right thumb and on right middle finger; ? early clubbing of fingers (i.e. loss of nail angle)—otherwise negative except for coarse tremor of hands at rest. Lower-negative, no edema, varicosities, ulcerations, no bone or joint tenderness. Neurological: physiological and equal reflexes throughout.

After admission to the hospital the patient was x-rayed and diagnosis of tularemia pneumonia was made. He was given penicillin, 50,000 units every two hours, day and night, for forty-eight hours with absolutely no change in the clinical picture.

On January 17 he was given a blood transfusion and at the same time streptomycin was given, first dose being one-fourth million units and then 125,000 units given intramuscularly every four hours until a total of 6,000,000 units had been taken.

On January 22 his mental condition cleared up and he began eating by himself, temperature staying normal. His pulse fluctuated between 100 and 120. Respirations dropped to 20 and stayed there throughout rest of hospital stay. He was discharged on February 4, his twenty-first hospital day, at which time his temperature was normal, pulse was 104, respirations normal, he was eating tremendously, his feeling of weakness had disappeared and he was generally improved.

Follow-up note of March 19, 1946 reads, patient is completely cured of his infection. He feels good. Weight up to 148 pounds and he is able to do considerable exercise and work around the house with no feeling of exhaustion.

This case is reported because:

1. It is the third case of tularemia reported in Connecticut.
2. It is the first recovery in the state.
3. It was cured by the use of streptomycin, after failure with sulfadiazine and penicillin.

It will be noted from the treatment given that very large doses of streptomycin were given and that the patient got relief after the first dose.

## PLACENTA ACCRETA AS A CAUSE OF CONCEALED ANTEPARTUM HEMORRHAGE

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**A** FORTY year old, white, gravida 8, para 8, eight months pregnant, was admitted to the hospital March 27, 1947 via ambulance with the diagnosis of "acute circulatory collapse." The only history available was that the husband, called from work, had found his wife lying in bed obviously very ill. The family physician on arrival sent her to the hospital. Further history obtained later from the patient revealed that she had been lying in bed

reading, after walking to and from the bath room, and upon turning from her right side to her back had suddenly felt an "indescribable sensation in her abdomen," and, becoming very weak and dizzy, she had called to her daughter. She remembers little else until long after admission to the hospital. At a single prenatal visit she had been told that she had a mild hypertension and a small amount of albumin in her urine. No history could be obtained of any

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traumatic episode during the pregnancy.

The past history was non contributory. There had been six previous full term, normal, spontaneous, uncomplicated deliveries including two sets of twins. There had been one miscarriage at four months in 1939 with a blood loss necessitating transfusions.

Admitted in a critical condition; T 98.6, P 102, R 22, BP 70/40; her chief complaint was abdominal pain which interefered with breathing. Examination of the lung fields revealed scattered wheezes and coarse moist rales over the main bronchi.

The apex beat was in the fifth interspace about three centimeters outside the mid-clavicular line. The heart sounds were weak and distant at the apex, but fairly strong at the base. A<sub>2</sub> greater than P<sub>2</sub>. Rate regular and moderately rapid. A little later the blood pressure had fallen to 60/54. Examination of the abdomen revealed a gravid uterus with the fundus two fingers below the xiphoid; fetal heart in the right upper quadrant, rate 140; head presenting above the pelvic brim. The uterus was tender to palpation, as was the abdomen at the lateral borders, but there was no apparent spasm of the abdominal muscles. The extremities were negative except for numerous large and tortuous varicosities of both legs and thighs, more on the right. There was no peripheral edema.

On catheterization, thirty cc. of urine was obtained. Yellow clear, acid, 1015, albumin 2 plus, acetone negative, sugar negative, many heavily granular casts, few epithelial and white blood cells.

The blood showed hemoglobin 8.7 gms., red blood cells 3,140,000, white blood cells 14,500, 72 per cent P., 10 per cent NS., 62 per cent Seg., 28 per cent L., plasma protein 5.5 gms. Blood type O. Rh positive.

It was thought that the patient had suffered a massive concealed hemorrhage probably due to partial premature separation of the placenta. The patient's continued complaint of abdominal pain, and the fact that repeated abdominal examinations revealed a uterus which seemed to be getting more firm, while the remainder of the abdomen remained soft further substantiated this presumption. She was given intravenous dextrose solution, plasma, and a transfusion which brought the blood pressure up to 130/70. Subsequent catheterizations at eight hour intervals obtained about the same amount and type of urine.

The fetal heart sounds disappeared about twelve hours after admission and labor pains set in, followed in another twelve hours by version and breech extraction of a six pound one ounce still-born. Continuous intravenous infusion of dextrose in saline was given throughout labor and the delivery, and oxygen was given freely. Manual extraction of a ragged placenta and membranes was done immediately after delivery of the foetus. A small amount of retained placental tissue was felt but not identified as no line of cleavage could be developed, and the uterus was packed. Contrary to the antepartum impression, there was no evidence of intrauterine hemorrhage found at delivery, and the total blood loss was estimated to be not more than 150 cc. The packing was removed twenty-four hours later with no loss of blood.

After the delivery, profound oliguria continued with developing signs of uremia, even though the blood pressure was maintained at 110/70 to 130/70. During the first eight hospital days the total urinary output was only 1,040 cc., while the fluid intake by mouth and by the intravenous route was 18,000 cc. The patient did however lose an unestimated amount of fluid through vomiting during the first four hospital days, and on the sixth day, after repeated small doses of Seidlitz powders, she had frequent loose watery stools. This loss was at least partially offset by repeated hot colonic irrigations each of several gallons of tap water. The non protein nitrogen rose to a level of 190.0 mgm. per cent, and the creatinine to 9.5 mgm. per cent. The hemoglobin fell to 5.5 gms., and the red blood cell count to 1,760,000. No jaundice was observed, and the icteric index was 8.80. Two blood transfusions brought the hemoglobin to 6.4 gms., and the red blood cell count to 2,680,000. An electrocardiogram was normal. Chest x-ray revealed only a dilated heart and evidence of mild cardiac decompensation.

It was the general feeling of the obstetrical staff as well as medical and urological consultants, that we were dealing with an acute kidney failure which would not respond to hypertonic glucose given by venoclysis, colonic irrigations, etc. The possibility of employing the method described by Seligman, Frank, and Fine,<sup>1</sup> and more recently by Goodyear and Beard,<sup>2</sup> for peritoneal irrigation in an attempt to reduce the azotemia was considered, but it was not felt that the existing laboratory facilities were adequate to cope with such a procedure.

On the eighth hospital day, seventh postpartum day, the patient, while being assisted off a bed pan, suddenly experienced an acute pain in the abdomen, and went rapidly into severe shock. Adrenalin and an intravenous infusion of dextrose in saline were followed by a moderate improvement in her condition. Signs of an intra-abdominal hemorrhage became obvious, as the abdomen was tensely distended and a fluid wave was demonstrated. Paracentesis with a small needle revealed a free flow of dark blood. An immediate abdominal exploratory laparotomy with simultaneous massive transfusion of blood seemed to be the only solution, as it was suspected that she had suffered a rupture of a blood vessel, probably a varix of the broad ligament.

The patient was taken to the operating room and three simultaneous transfusions were started in the arms and one leg; a total of 3,000 cc. of citrated blood being given in the course of one hour, before and during the operation. On opening the abdomen, there was a tremendous gush of blood and an estimated six to eight quarts of fluid blood and clots were removed. Rapid inspection of both adnexal regions showed no bleeding point as did exploration of the upper abdomen. A uterus about fourteen centimeters in diameter was delivered through the abdominal wound. On its right posterior aspect the posterior branch of the right uterine artery was bleeding briskly. The bleeding point could not be controlled with mattress sutures because the extreme friability of the uterine tissue allowed the sutures to cut through. A supra-cervical hysterectomy was performed, and the abdomen was closed in the usual manner around a drain in the cul-de-sac.

There was very profuse sero-sanguinous drainage from the abdominal cavity the first two days following operation, which was a source of serious protein loss. It was felt that the maintenance of a plasma protein level as nearly normal as possible was a matter of major importance as a contribution to the restoration of kidney function. The copper sulfate method for measuring the specific gravities of whole blood and plasma described by Phillips,<sup>3</sup> and his coworkers was found to be a very convenient and facile method for keeping a frequent check on the hemoglobin and the plasma proteins. Further transfusions and infusions of plasma were used to meet the indications thus found so that the hemoglobin and protein content of the blood stream were kept within low normal range.

The postoperative course was one of rapid improvement. The kidney function improved dramatically and the non protein nitrogen and creatinine gradually approached normal levels. The patient was allowed up on her tenth postoperative day and dismissed on her twentieth day after operation.

The uterus after removal showed partial placenta accreta, or, according to the classification of Kaltreider,<sup>4</sup> a partial placenta "percreta," with invasion of the chorionic villi through the uterine wall in the region of the posterior branch of the right uterine artery. The placental tissue still in position in this area could not be removed without tearing the uterine wall.

#### DISCUSSION

It is thought that this woman suffered three large hemorrhages. The first, prior to and leading to her admission to the hospital produced such severe shock that almost complete anuria persisted for eight days.<sup>5</sup> Hemorrhage undoubtedly occurred at the time of delivery and was masked by continuous infusion of dextrose in saline. This second hemorrhage produced a marked fall in red blood cells and hemoglobin after an otherwise bloodless procedure. The third hemorrhage a few hours prior to the laparotomy produced very severe shock. This series of hemorrhages with interval refilling of the circulation supplied the extraordinary amount of blood found in the abdomen.

Had the condition on admission been appreciated, and a hysterectomy performed as soon as the patient reacted from her primary hemorrhage, perhaps the result would have been better, but such intervention was thought to be contra-indicated by the acute urinary suppression and kidney failure. This kidney failure presented a different picture from that found in the toxemias of pregnancy in that there was no edema nor hypertension and the urine, although reduced in amount almost to complete suppression, was clear, of low specific gravity, and contained only a moderate amount of albumen but a tremendous number of coarse granular casts. The resumption of kidney function and a marked reduction in the azotemia following the operation were contributed to by the dilution incidental to intravenous administration of a very large amount of fluid: viz., about 4,000 cc. of citrated blood and about 3,000 cc. of dextrose solution in less than twenty-four hours.



## SUMMARY

A case of "Partial Placenta Percreta" which caused repeated massive concealed hemorrhage is presented.

In this case the first hemorrhage produced such severe shock that persistent anuria and early uremia followed.

Massive transfusion of blood before and during the operation permitted a successful hysterectomy.

The Phillips method of determining the blood and plasma specific gravities permitted a close post-operative follow up of the hemoglobin and plasma proteins which were important in the revival of kidney function.

Seven weeks after dismissal from the hospital the patient was in good vigor, wt. 159 lbs., BP 126/78., urine 1020 acid, no albumen or sugar, heart sounds clear.

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## MINERAL OIL — A HEALTH HAZARD

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RESEARCH physicians and nutritionists have been warning for several years that the ingestion of mineral oil (liquid petrolatum) has a deleterious effect on human beings. Nevertheless, many persons have continued to take it by mouth, in the belief that its only actions were those of softening the feces and lubricating the intestines, thus causing easier evacuations. Notable among the constant users of mineral oil are pregnant women and women wishing a substitute for vegetable oils in reducing diets.

During the war, because of the shortage of oils of vegetable origin compared with the availability of mineral oil, salad dressings made with mineral oil instead of vegetable oils became more numerous on market shelves, and new uses for it were found; such as the preparation of pop-corn, salted nuts, doughnuts, croquettes, potato chips, etc.

## USE OF MINERAL OIL CONDEMNED

At the annual meeting of the American Medical Association in Cleveland on June 4, 1941, in a panel discussion on drug therapy of the alimentary tract before the section on gastro-enterology and proctology, James W. Morgan, M.D.,<sup>1</sup> of San Francisco, summarized the research on the use of mineral oil and concluded, "It would not be too unfair to say that in some respects liquid petrolatum has earned its niche in the section of toxicology rather than in pharmacology."

In 1943, the Council on Food and Nutrition of the American Medical Association<sup>2</sup> authorized publication of a report summarizing research on mineral oil and announcing its withdrawal of its acceptance of food products (such as salad dressing) containing mineral oil.

In April, 1946, the Connecticut Dairy and Food Commission ruled that salad dressing containing mineral oil could no longer be offered for sale under any form of labelling. In fact, any food either made with mineral oil or cooked in mineral oil is

considered an adulterated food under section 896c of the 1939 Supplement to the General Statutes.

Because of these decisions and in the presence of continued large sales of mineral oils and mineral oil emulsions at drug stores, it is believed appropriate at this time to review some of the literature which has appeared in the past few years reporting research showing that mineral oil by mouth is harmful.

#### INTERFERENCE WITH VITAMIN AND MINERAL

##### ABSORPTION

*Vitamin A.* That this vitamin, and especially its precursor carotene, is absorbed from the intestinal tract by mineral oil, has been demonstrated especially by A. C. Curtis, M.D.,<sup>3,4</sup> of the University of Michigan Medical School and his collaborators. Their experiments were made on human beings, to whom were fed various mixtures of carotene, mineral oil and vegetable oil. Results were measured by determinations on blood carotene. They found the carotene content of the blood raised when crystalline carotene was fed in vegetable oil to "persons on a constant diet," and "a reversal of this effect" when liquid petrolatum was added to the mixture. They did, however, find that when the liquid petrolatum was given in a single dose at bedtime there was much less effect on the carotene absorption than when it was used at the same time as the carotene-containing mixture.

Curtis calculated that at body temperature an ounce of mineral oil could dissolve 140,000 international units of carotene, or fourteen times as much as that ordinarily contained in an excellent diet.

*Vitamin D, calcium and phosphorus.* Smith and Spector<sup>5</sup> in 1940, showed in animal experiments that five to ten times as much cod liver oil was needed to heal rickets in rats when their diet contained ten per cent mineral oil, and that mineral oil interfered with bone-calcification in puppies given adequate amounts of phosphorus and calcium and five times the adequate dose of cod liver oil.

*Vitamin K.* Not only have animal experiments given evidence of the absorption of Vitamin K by mineral oil, but Javert and Macri<sup>6</sup> in a study on the effect of the oral administration of vitamin K on the prothrombin level of pregnant women, were convinced that the effectiveness of vitamin K in raising the prothrombin blood level was impaired by the ingestion of mineral oil. Their conclusion was that "The oral administration of vitamin K to pregnant women may prove of little or no value unless the simultaneous use of mineral oil is curtailed."

#### INTERFERENCE WITH NORMAL PHYSIOLOGIC PROCESSES OF INTESTINAL TRACT

J. W. Morgan<sup>1</sup> writes as follows of the effect of mineral oil on the intestinal tract: "The rectum is not a reservoir. Functionally it is but a short passage to the exterior. The true reservoir is formed by the sigmoid and the descending and transverse colon; feces may remain in this portion of the bowel for some time without ill effect. Once the feces enter the rectum, they should be evacuated with the establishment of the defecation reflex. This initiates a strong peristaltic contraction of the colon; the contraction of its longitudinal fibers and the consequent shortening of the rectum by the levatores ani, combined with the simultaneous onset of peristalsis, accompanied by a coordinate relaxation of the anal sphincters, result in the evacuation of the feces. Failing this, as Alvarez, Hurst and others have pointed out, a person will have pressure, symptoms of headaches, furred tongue, foul breath, malaise and mental sluggishness.

"The use of liquid petrolatum as a laxative may be severely criticized on the grounds that it interferes with this normal physiologic process. The competence of the rectosigmoid "valve" is destroyed and as a consequence the reservoir effect of the more proximal bowel is lost. Continual leakage from above results in the rectum being kept partially full most of the time and causes its conversion into an abnormal receptacle for fecal material. There is not sufficient pressure to initiate the defecation reflex, but there is enough fecal material present to cause symptoms of irritation.

"When liquid petrolatum is present in the rectum, complete evacuation is impossible. Whatever the degree of emulsification in the intestine, one always finds a tenacious layer of a dirty mixture of oil and feces covering the rectal mucosa. In those having taken liquid petrolatum one can nearly always discern the presence of the oil macroscopically, making it impossible to examine the rectal wall properly. This is the fact whether the patient has or has not defecated prior to the examination. Often under these conditions colon flushings are necessary to accomplish proper visualization."

#### INTERFERENCE WITH ANAL HYGIENE

Morgan<sup>1</sup> states further in his article that, because of leakage of oil from the rectum, constant users of mineral oil may have pruritus ani from the deposit of fecal material about the anus.



MINERAL OIL SHOWN TO BE ABSORBED

Animal experiments have shown that the belief that mineral oil is not absorbed by the intestines is untenable. Channon and Collinson<sup>7</sup> in work on pigs and rats in 1929, Stryker<sup>8</sup> in work on rats and rabbits in 1941, have shown that animals autopsied after ingestion of mineral oil showed deposits of the oil in the liver, the walls of the intestines and in the mesenteric lymph nodes. Stryker<sup>8</sup> showed in addition the same deposits in two human beings at autopsy.

LET US PREACH AGAINST USE OF MINERAL OIL

Physicians should not only *not* recommend use of mineral oil but should warn patients against its use. Only in this way will its consumption, detrimental to health, be reduced. More consideration should be given to the causes of constipation and their conquest through changes in diet, through ingestion of fluids, and by psychological adjustments. Especially in pregnancy should mineral oil be banned. To the pregnant woman and the developing fetus, more not less, vitamins and minerals should be available.

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THE WAY OUT — POSTWAR MEDICAL TEMPTATIONS AND SOLUTIONS

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THE DOCTOR'S REAL TEMPTATION

These are days of change. Whirl is indeed king. Everyone knows that. "Survey, then plan" would seem to be a reasonable course for us doctors,—which is why, for example, the American Academy of Pediatrics has recently undertaken its national study of child health services. Now is the time for us to plan in such a way that we may not be "tempted" to give the people anything less than the best possible medical care.

Perhaps, I think too well of my profession; but I am not including "ordinary greed" among the medical temptations under consideration. By this I mean

the kind of thing which more or less justified George Bernard Shaw's dictum that there is no greater menace to society than that of a starving doctor: making unnecessary house calls, removing normal appendices or tonsils, etc.; or in the event of the spread of prepayment or insurance medicine, "holding back," giving patients less than full measure, pressed down and running over. After thirty years in the profession, I can say with assurance that the conscienceless medical crook is a rare bird of prey. With increasing care in selection of medical students, especially plus more watchful application of ethical criteria, he will become still rarer.

The great majority of M.D.'s deserve Stevenson's famous tribute. They even deserve the encomiums which, significantly enough, are paid them when they die young: "No patient was too poor for him to see at any hour of the day or night. He couldn't

bring himself to refuse to add another family to his overcrowded list."—etc.

The great and insidious temptation for us medicos is exactly that: to try to do too much. One's practice, or one's research, is the right size for a day or so: too small before that day, too unwieldy afterward. Being a practitioner, I can speak better for that group. For the laboratory investigators and teachers, smaller in number, often brilliant, always underpaid, suffice it that they are more nearly masters of their fate, and far more commonly get a good night's sleep.

Among the practitioners, the besetting sin, the great transgression,—“taking on” more patients than can be given proper care—assails physicians, pediatricians, general practitioners far more than it does the surgeons. Those who wield the knife must do so skillfully—and not too often. They should not be mere technicians, bone carpenters, intestinal tailors. Their diagnostic judgment, their familiarity with the principles of physiology and biochemistry should take precedence over their maneuverings with sterile hardware. Thus, their training, especially in so difficult a field as, for example, that of neurosurgery, requires many years, and entitles them to some, at least, of that extra emolument which at times annoys the bill payer of the family and forsooth the hard-plugging medicos who call for surgical help.

This leads us to our main objective: run-of-the-mill medical practice. Of this we teach our students that perhaps ninety per cent will recover no matter what the doctor does; that the remaining ten per cent, plus knowledge and application of preventive measures, more than justify—nay, require—his existence.

#### THE CHANGING MEDICAL SCENE

Woe to our lay brethren when we physicians have the wrong idea of what constitutes adequate medical care! Conversely, and fortunately, woe to us physicians when our patients are educated to the point of demanding the good care which we in our complacency (seldom laziness, please note) fail to provide. Complacency? Yes, all too often; but it is likely to be the complacency born of overwork,—of toil so constant, so exacting that it not only makes the toiler put a high value on his toil, but also prevents him from comprehending how inadequately it is distributed.

Adequate medical care: here definition is vital. It

is not, has not been, and cannot be the same from year to year. A generation ago, a doctor might, in the language of Oliver Wendell Holmes,

“Skip upstairs, inquire, inspect, and touch,  
Prescribe, take leave, and off to twenty such.”

He could, and did, glance at a tongue, take temperature, pulse, and respiration, thump a chest, write an all inclusive prescription; and inasmuch as little more was known of accurate diagnostic methods, inasmuch as therapy was mainly palliative anyway, he could fairly be said to have done his duty.

From the patient's point of view as well as the doctor's, how the picture has changed! Now, if careful history taking and physical examination leave any doubt about the diagnosis, the physician or the surgeon (or both) can and must resort to blood counts, blood chemistry, electrocardiograms, various x-ray procedures. Patients may, and a few do grumble at the expense of these valuable aids. But in the doubtful cases, they not only reduce diagnostic error to a minimum, they lead to the institution of proper therapy.

Research being what is is (though by no means what it could be with adequate financial support) we cannot call it mere luck that chemical and biological methods of treatment have kept pace with, if not outstripped, methods of diagnostic precision. Who should or should not receive a sulfa drug, or penicillin? Of which patient can we say, “Put a needle in there and you'll get pus?” More and more, the correct answers are forthcoming. So often is this true, that gratitude on the part of patients is reaching an inverse ratio. They don't know what they're missing! Since the introduction of the sulfa drugs, the reduction of the number of mastoidectomies, of rib resections for empyema, etc., is obvious to us older practitioners. As for the patients, one doctor waggishly wrote:

“I'm glad recovery's so quick,  
But they don't realize they've been sick.”

Each patient, then, must have more time and effort spent on him, even though present day treatment is far more efficacious than that of a decade ago. “It's coming to him,” whether he's rich or poor, and he knows it.

#### THE COUNTRY DOCTOR

This kindly, omniscient hero of song and story, who, as one admirer inaccurately put it, “could treat everything from an ingrowing toenail to a brain tumor,” is making his exit. Medical science has



developed to the point where no one practitioner, however "general," can cover it with justice to the patient. But ability to recognize, and, when necessary, to call in those who best can help in rare and difficult conditions requires and will continue to require skillful practitioners.

Fortunately, means of communication and transportation have developed simultaneously with medical knowledge, so that now only a few missionaries, or pharmacists' mates in submerged submarines are likely to find demands for such impossible versatility thrust upon them. Rural practitioners, and urban ones too, owe it to their patients to send them to specialists and to well equipped "medical centers" when they develop evidences of rare or difficult maladies.

Again, the "country doctor," without the stimulus of a medical school whose faculty and students would "keep him on his toes,"—without libraries, scientific meetings and discussions,—is all too likely to forget that when a doctor lets himself get too busy with patients, he loses touch with medical progress. "The busier he is the dumber he gets" may apply to him, and painfully. Constant ringing of the telephone, irregular interrupted meals, all too little sleep, help make for exhaustion rather than alertness. Think, for instance, of the war-time situation in one Missouri town of five thousand, cared for by two doctors both over seventy!

#### THE CITY DOCTOR

Naturally, the above considerations constitute a lure to the younger physician to practice in the medically more stimulating urban centers. Here he is led away from, rather than into, the temptation to drift into archaic or sloppy methods of work. Here others can help keep him from being too overworked to give his best to his patients.

As far as financial pitfalls are concerned—keeping in mind that the war is now over—it ordinarily takes the city practitioner longer to clear expenses; but ultimately his income, like his outgo, is higher. His chief urge, depending on his character and that of his wife, is to make it too high. If he has too much social conscience, his charity work alone can run him into an early grave—where even the poor will have to admit he can't help them. Happily, physicians with social consciences are not as rare as many of the laity think. One such M.D. told me in all seriousness that the really valuable part of his work was that for which he got no payment. As might be

expected, such men—and women—carry more than their share of the "charity load;" witness the late Dr. Williams of the New York Hospital, who during World War I gave fifty hours of his time without pay each week, and "spent the rest making a living." He lived much longer than any of his friends had expected.

#### THE ANSWER

Clearly, medical progress being what it is, the doctor's training can never stop, must never lag behind his practice, an end which will be thwarted by overwork as it will by laziness. Even since the end of the war, the doctors can't keep up with the demands upon them. Overwork is still the order of the day—and night. Medical care, even for the people of America, is still lamentably inadequate. There can be only one answer: more doctors—with the immediate proviso that quality must not be sacrificed to quantity.

The validity of this answer is well attested by Dr. Martha M. Eliot, associate chief of the Children's Bureau (testimony before the Senate Committee on Education and Labor, May 1, 1946): "We must find ways and means, nationally and in the states, of training a sufficient number of professional people. We have now about 2,500 pediatricians. We estimate that we need at least 7,400. We need probably 5,000 more obstetricians, 1,000 more orthopedists. We need 34,000 dentists trained in children's dentistry. We have 19,000 public health nurses and need 50,000 more. We need at least 15,000 additional graduate nurses for institutional and private duty. We need some 10,000 additional psychiatrists, to expand services for children particularly into areas now without them.

"Over 100,000 babies die in their first year of life in the United States. The lowest rate in 1943 was in Connecticut, 30 per 1,000 live births. In New Mexico, 92 babies died in their first year per 1,000 live births. Not only do mothers and babies have a better chance to survive in one part of the country than another, but they are better off if they are born into white rather than Negro families. The maternal death rate for Negro mothers in 1943 was 143 per cent, the infant death rate 64 per cent higher than for white. . . . We must tackle this problem with the same ingenuity with which we organized ourselves for action during the war, but utilizing the lessons we learned from the war-time programs."

Dean Raymond B. Allen (*Medical Education and*

*the Changing Order*, Commonwealth Fund, N. Y., p. 127 ff.), discussing the supply of medical students and physicians, writes: "Of 12,200 applicants for admission to medical schools in 1930 (U. S. A.), 5,849 students were admitted. Beginning in 1940, the schools increased their enrollments in the first year class by 10 to 15 per cent." This, with "acceleration," means that between 1942 and 1948 there will have been graduated about 10,000 more doctors than would normally have been the case.

"It is well known," Dr. Allen adds, "that there are more applicants for admission to medical schools than there are places in the first year class, but it is not widely appreciated that the ratio is only about two to one. All of those rejected are mediocre to poor aspirants." "Moreover, some students who are admitted represent very poor academic risks."

Here, now, is the nub of the matter. If Dr. Allen is correct in saying that all the rejected aspirants for admission to medical schools are mediocre to poor students, then any suggestion for continuing increased enrollments into peace-time is unsound. It would be far better to take steps as immediate and drastic as possible toward two kinds of redistribution of doctors: (1) Attract more, better, and younger medical men and women to small towns by providing better county hospital and laboratory facilities—a procedure long advocated, delayed mainly by lack of funds and building materials, and presenting but one valid drawback—that no matter how much chromium-plate and white enamel the new operating rooms might display, the quality of major and special surgery performed therein is likely to be of less than the highest order. Few general practitioners in the country (or the city) have any desire to attempt such surgery anyway; they are glad to drop their "hot potatoes" into the laps of the city specialists.

(2) The second type of redistribution referred to must unfortunately remain hypothetical—no matter how desirable: the early classification of medical students into those electing surgery and its specialty branches, including obstetrics and gynecology, and those electing internal medicine and pediatrics. Such classification is impracticable because (a) many students do not—and should not—decide until the latter part of the senior year about the specialized work, if any, they want to do; and (b) the general hospitals, where as interns they really learn diagnosis and treatment, contain a proportion of surgical patients far higher than that which will obtain in

their private practice. In the medical branches only a very small fraction of the patients require hospitalization. Thus the desideratum of training a large number of medical and general practitioners; and to "supertrain" a relatively few surgeons, is a procedure which cannot be determined upon early in the medical course.

Any dean, or executive faculty would, and should view with alarm an attempt to increase the student enrollment in his or their medical school. Each school has its laboratory capacity, its setup for hospital teaching, its preclinical and clinical teaching personnel. Only the strain of war, the call of patriotism, and government money have been capable of producing expansion here. But the need has not passed with the coming of peace.

It is indicated from the foregoing that our medical schools should continue in peacetime to produce more graduates. But before discussing how the schools and hospitals are to give the additional students adequate training, it is absolutely essential to establish that the additional number of applicants needed, but at present rejected, would be good to excellent, rather than mediocre to poor material.

First, we should by now be in a position to assess the quality of the increment taken in during the war. It is my belief that their services will prove to be of great value if only by comparison with the extent to which their lack would be felt.

Again, although as recognized an authority as Dr. Allen states that only about twice as many applicants are rejected as accepted, in many of the best schools, the rate is far higher. In at least one instance, 1,200 applied and less than 100 were accepted for the freshman class. (Many of these were, of course, "multiple applications.")

If, then, I am correct in believing that the wartime increase of 15 per cent in medical school enrollments can and should be absorbed in peacetime, without "acceleration," the question arises whether several new medical schools should be opened, or whether the apparently impossible task of continuing to absorb the wartime increment of 10 to 15 per cent into the existing Class A schools should be undertaken. Would such schools *ipso facto* lose their Class A status? Could their faculties, their exchequers "manage"? Could their hospitals and clinics be "stretched" to accommodate the "load"?

Obviously, hospitalization is now everywhere inadequate. Even the older staff members have difficulty getting their patients admitted. Younger men



graduating from their internships or returning from the armed services are "just doing the best they can" in the matter of hospital appointments. And in the smaller towns, osteopathic and "private" hospitals are filled to capacity.

A talk with Acting Dean Robert A. Moore of our medical school (Washington University, St. Louis) very easily convinced me that to expect any of our Class A Medical Schools to enlarge significantly its enrollment and retain its present high quality of education would be utterly impossible, because of limitations of facilities and staff. Medical education is largely at the graduate level. The most effective teaching exercises are conferences, seminars, and demonstrations to small groups of students. Beyond a certain point, quality and quantity bear an inverse relation to one another.

I speak only for myself, as one of the scribes, not as one having authority. I am but a "part time instructor without stipend." But I believe that there are a few excellent colleges and universities which, with adequate funds, could have equally good medical schools and hospitals added to them. For reasons too numerous to mention here, and agreed to by medical educators, these schools should be built on or near the college or university campuses.

Certain universities which, like that of Missouri, offer the two preclinical years, should be enabled to provide the last two.

How? If private resources are not available, which evidently they are not, there is no better cause to which public funds could be devoted. Priority here in money and material is far more important than that so readily granted for battle wagons. Wartime help from the Government seems to have done our medical students and schools no harm. If necessary, let us have it in time of peace—with all safeguards as to standards and professional control.

In support of this recommendation, let me quote at some length the opinion of one full time professor in an excellent medical school.<sup>1</sup>

"Congress should provide facilities for direct financial aid to first-class medical schools now existing and for others to be formed, and make such aid provisionary to the maintenance of standards to be

set by the entire group of medical schools themselves.

"Congress should give direct aid to medical research and not only by setting up new agencies for specific projects but by broad grants to existing institutions. Medical education and research cannot be separated. The total amount spent for medical education and research should be multiplied many times. . . .

"Not only should more hospitals be constructed, but, far more important, support of teaching within those hospitals should be specifically made. Money for the support of resident physicians in many hospitals would often do far more good in improving medical care than direct financial aid to the patients. . . .

"Many more good young physicians would spend five years in hospital training if they could be financially supported and if more teaching hospitals existed."

Dr. Wilson sees the handwriting on the wall. He sees that financially, medical education is in a period of transition. He sees that in the past, and still more so at present, the big private fortunes and foundations, generous as these have been, cannot give adequate support for so expensive (and worth while) an enterprise as medical education and research—expanded as these need to be. Dr. Wilson is chairman of the Academy of Pediatrics's committee now embarked on the study of pediatric education throughout the country. It will be interesting to see whether the findings of that committee will confirm some of the observations made herein.

In conclusion: except for certain faddists and cultists, our people are alert to the immense values of recent developments in medicine. And they are more alert than are we doctors to the fact that proper medical care is not available to many, many of their number. The time for medical educators, in collaboration with government authorities, to take adequate, courageous action, with ultimate saving of lives, is now.

#### REFERENCE

1. Dr. James L. Wilson; letter to Senator Pepper, published in the *Journal of Pediatrics*, 28: January, 1946, p. 112.

## PROGRESS IN MEDICINE — FROM HORSE POWER TO JET POWER

B. B. ROBBINS, M.D., *Bristol*

**P**ROGRESS IN MEDICINE—From Horse Power to Jet Power, concerns a period of medical progress which I hold very dear to my heart, the past fifty years. Undoubtedly, after close examination, I should discover my sentiment associates closely with the fact that it is the time in which I have lived and practised. Somehow, I believe, nevertheless, that this period is important in the annals of medical science, that in the centuries to come young men will be told in their classes that this fifty years saw a magnificent change, the change from horse power and all that it symbolizes to jet power and all it means in actualities and in hopes and dreams.

When I look back to the early days, about the time of my graduation from New York University's medical college, 1894 to be exact, I find it difficult to believe that techniques were as crude and knowledge as limited as we now realize was the case. True, we saw many improvements needed, but we hardly considered ourselves to be in the "dark ages." After all, we had looked back to such great men as Harvey, Jenner, Morton, Pasteur, Lister, Koch and others for inspiration; indeed, these immortals had lighted the fires of medical evolution which were to be fanned into flames by Behring, Ehrlich, Reed, Gorgas, Roentgen, Roux and others. They had waged major campaigns in behalf of scientific medicine and had exterminated the greater portion of the quacks, that it would be possible to have sanitation and the practice of the healing art with intelligence and confidence.

The year before my graduation from medical school I had accompanied a friend, Dr. Bowers, to the home of a patient stricken with laryngeal diphtheria. A young girl, twelve years old, was choking to death from this terrible disease. Later, the doctor told me, "She will be dead tomorrow." I asked if nothing could save her; he shook his head in the same way we shake our heads today when confronted by an incurable case of cancer or poliomyelitis.

Four months after graduation I moved to a thriving village of 8,000 people. Naturally, in those

good old days a doctor's transportation depended on the horse and buggy, and so I became a typical small town doctor replete with black bag and horse and buggy. Those so-called "good old days" weren't so good after all, not when the typical delivery and operating table was found in the nearest kitchen, not when the family and neighbors served as nurses, not when water was scarce and sanitation without emphasis, and certainly not when medical instruments were so few. It's a wonder anyone lived!

Speaking of medical instruments, it wasn't uncommon to find a doctor without a stethoscope; that was the rule, not the exception. The average physician, the old "saw-bones," persisted in the older method of putting his head on the patient's chest while he counted. The thermometer has undergone some drastic changes also; we had such a gargantuan instrument, it had to be placed under the patient's arm for a temperature taking. Usually it was about eight inches long, for the calibrations couldn't be successfully determined on a shorter instrument.

The diagnostic methods of those days were exceedingly crude, very rough and inaccurate. Armed with a microscope and a test tube the physician tried to combat the illness. The laboratory, as we know it today, didn't exist. The doctor would depend largely on the patient's medical history, a point which, of course, we still believe in, but not without supplementary information coming from internal investigation made possible by many devices not known at the turn of the century. By questioning the patient about his aches and pains of the past the doctor learned something about the current illness, but he didn't stop there; he also questioned him about the things from which he expected to suffer. Frequently the physician claimed he could smell a disease. It was a common practice to go into the sick room and try to smell out the disease. As a matter of fact, when typhoid was involved the doctor usually could smell it. In this period smallpox was being defeated by preventive medicine, that is, by vaccination, but it was the only disease of a first magnitude that science

*Address of retiring president, Hartford County Medical Association, prepared for annual meeting, April 1, 1947, not delivered*



controlled. Even these methods of vaccination were haphazard, for they were often causing large sores and bad scars. Then, too, some didn't work efficiently.

Surgery, as I said before, was a matter of a kitchen table technique. My first delivery came out quite well, though it took place in an old mill house, and twins at that. My first appendix case was very simple; the patient got well all by himself. Called to a small, outlying country village, I attended a young lad with an abscess well on the way to a rupture. I went quickly for my surgical instruments, but when I returned the abscess had disappeared, having passed through the intestines with blood and pus in the stools. The boy recovered fully.

Though the horse and buggy seem a thing of the past, no doctor in the old days could afford to be without one. Take as an example a case I was called on in which a wood chopper had fallen on his axe out in the woods where no help was available. He had split his knee-pan open; ligaments were cut and had to be stitched together; another row of stitches was needed to hold and draw the ligaments together; and another to hold the kneecap in position. The accident had happened near a small wood chopper's hut away from everything; no assistance was available and the water could be heated only over a little fire in the ground.

With my "trusty" horse and buggy, as the saying goes, I spanned the ten miles into the woods to take care of that damaged knee. I didn't take any longer than possible, but a horse isn't a matter of cylinders and gasoline. Luckily it wasn't the wood chopper's throat that was cut, and so I managed to do the job successfully out in the little hut.

Several weeks later, when the wood chopper's camp was being vacated, he called me up to see him again. I found the joint healed beautifully with perfect motion in the knee, and the only worry the woodsman had concerned my bill. He had nothing but a pig, and he urged me to take it, the value being about \$2. I put the grunting two dollar bill into my buggy and returned home.

Maybe it's just as well we didn't have automobiles, for the fees we doctors received wouldn't have paid for the gasoline; fortunately, the horse preferred hay. I admit I felt rather chagrined about the entire matter, for I was getting a dollar for calls just around town. Office calls were fifty cents. In our town I was fortunate to get those prices, for few people had much currency. The majority could pay part

in cash and part in farm produce. Some would pay with just apples or potatoes, or even wood.

The change of the transportation means of the rural doctor, from horse and buggy to automobile, may well symbolize the alterations effected in medical science. Along with the doctor's problem of time and distance, the problem of many communicable diseases, too few instruments, inaccurate diagnosis, kitchen table surgery, unskilled help, unsanitation, and other "saw-bones" conditions generally have become extinct. And I must say, if the price for all these wonderful improvements is the sacrifice of the horse and buggy, I am glad I paid it.

Diphtheria met its nemesis in the person of a Prussian army surgeon, Emil von Behring, who succeeded in the discovery of a toxin-antitoxin. Actually it was first used in Berlin in a clinic experiment to save a child; this was in 1891. It arrived in the United States too late for the young girl I had seen choking to death to be saved. Nevertheless the prophylactic was developed in New York by William Hallock Park as early as 1915. Outbreaks of the disease are now practically unknown in communities where immunization of preschool and school children only is part of the normal routine.

Other communicable diseases have met the same fate. Typhoid, the disease that one could smell but not cure, has long since been controlled. Measles is now considered under control to the extent that routine treatment cures those afflicted in a very short time. Others of the saliva-borne diseases such as scarlet fever and tuberculosis have been reduced considerably in proportion to their deadly influence in the early days of this century.

The discovery of the x-rays by Roentgen has begun, it seems, a continuous improvement in the physician's equipment. His discovery in 1898 seemed at the time valuable only for the investigation of bone conditions; gradually, however, others following his line of endeavor have made possible the review of the organs and other parts of the internal tracts. The injection of air into the various cavities began this accomplishment, but it was only when a test meal was developed that success in this tangent was made; the gastro-intestinal tract was outlined. Then, dye substances were used, and lipiodol, injected in the spinal column, the brain ventricles, and other parts of the body, successfully demonstrated internal functions never before witnessed by the human eye. Tetraiodophthalein showed up the gall-bladder, iopax and neoipax for the kidney, thorium

dioxide the liver and the reticuloendothelial system.

Various electrical devices which transfer the functions of various organs within the body to records which can be seen on a moving screen have given great aid to further the investigations of internal disorders. The electrocardiograph, tracing and indicating the functions and motions of the heart, the plethysmograph and the various types of manometers, the sphygmograph and various other graphs which have come into medicine—all of these have brought a greater knowledge to the physician, and consequently, a great improvement in his skill.

The microscope has been supplemented with other electrically lighted instruments to help the investigation of body passages. We have today the retinoscope, the laryngoscope, the bronchoscope, the otoscope, the cystoscope, the fluoroscope, each bringing new insights.

Not only has the eye been magnified by these many new instruments; the ear has been extended also by radio-amplification. It is now possible to amplify the heartbeats, and quite recently the heartbeats of a patient, stricken with heart disease in Chicago, were sent over a telephone wire into a great auditorium in Atlantic City where three thousand physicians sat and heard them. This feat, of course, had no material value, except that it reveals the advance of medical equipment.

Yes, the doctor with his gargantuan thermometer and stethoscope has been replaced by a physician skilled in the methods of using these newly devised instruments to the best advantages. Naturally the 1947 doctor cannot carry a laboratory, or all these machines, therefore, he must be satisfied with second-best by having direct access to the laboratories in which they are used. Of course the telephone, the automobile, and the airplane, if necessary, easily can make up any time lost in sending information, or even the patient himself, to the laboratory. With the assistance of this great collection of instruments to tell the physician more about the patient's troubles, guess work in diagnosis is greatly reduced. The doctor doesn't need to smell out the disease or distress the patient with detailed inquiry; instead, the various instruments speak for him an amount of information of which he himself is not aware.

Kitchen table surgery has also joined the passing parade; in fact, when the news carries an item of an emergency operation or birth, the feat becomes a community discussion, particularly if it was performed in the kitchen. Such a change of attitude at

first seems a bit ludicrous to an old "saw-bones" like me, but in essence we recognize this change in public attitude as a great tribute to the efforts of medical men to improve their profession. Few people would agree to an operation in their homes today if they had time to reach a hospital. Not only have improvements in hospital techniques been multiplied, the public has been educated to require the right kind of treatment in healthy circumstances. People know that where there is filth, there also lies a danger of infection. They may not know the name Joseph Lister, but they do know what he stood for.

The number of hospitals has increased many times since the day I sewed up that wood chopper's kneecap. Professional assistance and equipment stands ready around every corner to serve the needs of an ailing person. About 1900 we had less than three thousand hospitals in the United States; today we have over 7,500 hospitals with not only physicians and registered nurses, but also practical nurses, pharmacists, cooks, dieticians, orderlies, ambulance drivers, laboratory technicians, physical therapists, anesthetists, and varieties of medical assistance undreamed of in the early days. No longer do the large cities hold a monopoly on the hospital; rural communities are purchasing small hospitals to look after themselves.

Pregnancy no longer causes the fear and difficulties that often were known in the past. The modern woman consults with her doctor from time to time, carefully watching her diet and observing the requirements brought about by new obstetric knowledge. No longer is a birth something to keep private. Public attitude is gradually changing so that a pregnant woman may walk the streets without being conscious of causing attention. To most doctors and the majority of parents having a baby is just having a baby, but to others a special effort is necessary. An obstetrician is called upon for the delivery; he, of course, requires an obstetric nurse. After the delivery the baby is handed over to the pediatrician and the pediatric nurse for proper care; thus, we see the age of specialization. Fundamentally the mother, however, still carries out the same style of performance.

Nevertheless, under care of the specialists or just an every-day doctor, the modern mother has a greater chance of pulling through than did the 19th century mother often afflicted with toxemias and eclampsia. The rates for the maternal and infant mortality have dropped considerably; new knowl-



edge of the glandular secretions have meant increased freedom from pain and distress to millions of women. The problem of "blue babies" has been greatly relieved by operations on the heart and the great blood vessels.

The syphilitic cures have been a blessing to all mankind. Not without Schaudinn's discovery of the cause of syphilis could the work have begun. I well recall the years in medical school when syphilis was regarded with about the same discouragement as we sometimes hear today concerning cancer and polio. Then came Ehrlich's contribution, then Metchnikoff, then Roux, then World War II and the successful application of sulfa drugs and penicillin; all of these developments have become and are now the history of the present syphilitic treatment which we complacently call "standard procedure."

Another significant discovery was the construction of a pancreatic extract by Drs. Banting and Best in 1921. This extract, better known as insulin, successfully took effect in 1922 on a 14 year old boy stricken with diabetes.

Advances in the field of nutrition have meant increased health and functional ability to people throughout the world. By reinforcing bread with such substances as iron, thiamine, and nicotinic acid the natural tendencies of the body are aided and longer life made normally possible.

The treatment of even the most deadly and painful diseases as cancer and tuberculosis, has undergone vast improvements. Experimentation has shown that the new drug, streptomycin may prove to be a remedy for tuberculosis. It has successfully taken up the fight where sulfa drugs and penicillin have left off. Chiefly used against bacteria which inhabit the intestines, it has done effective work against typhoid fever, cholera, and dysentery. Active in urinary tract infections and against many types of surgical infection, this drug shows signs of becoming one of humanity's great benefactors.

Certainly, the recent World War has well demonstrated that medical skill and knowledge is constantly on the move in its campaign against disease and other body ailments. Of the 570,000 wounded in this war, as many as 360,000 were returned to some sort of duty. Approximately 25,000, or 4 per cent died of wounds. Concerning disease, only 6 men in each 10 thousand died each year. Actually, this death rate is lower in disease than that of civilians in the same age groups in the United States; yet

these soldiers lived in every part of the world under adverse physical and sanitary conditions.

Insect-borne diseases have always had great influence on the course of operations throughout military history. The campaigns of our army in remote Pacific islands and other places would have been far more difficult except for the rigid development of highly effective insecticides and repellants. The disease-bearing lice, mosquitoes, flies, and flies-in-general were controlled by the use of DDT.

Early in 1944 a serious typhus epidemic developed in Naples with as many as fifty cases a day. DDT dusting stations were set up, and by March more than a million and a quarter persons had been processed through them. This with an extensive vaccination program brought the epidemic under control within a month. What a feat this was! And typical only of the present day. Never has any program on such a large scale been carried forth so systematically and with such a low percentage of deaths.

The development of methods for handling whole blood on the battle field was a great contribution to surgery. While plasma served its purpose, it didn't combat shock and make the wounded ready for surgery as did whole blood. Blood banks were established in every theatre of war; whole blood could be kept in supply by air shipments from the United States. The advanced surgical stations could keep it under proper refrigeration for as long as 21 days, and thereby stand prepared to supply any and all emergencies.

And still many more improvements in medical equipment and techniques come. New fingers, alive and growing, can be grafted on a fingerless hand, from other parts of the body's skin and bone. Many paralyzed limbs have been made to move. Congenital difficulties, such as hunchback, gonorrhea, syphilis, and others, can be eliminated at the early moments of birth. Already enough has been discovered about radioactive isotopes to promise great progress in the attack on such conditions as hyperthyroidism and lymphatic leukemia. New hope has been found in operations on those afflicted with cancer in the gastrointestinal tract as well as in the lungs; both are conditions at which a doctor a generation ago would have shaken his head.

Naturally I cannot attempt to cover all the developments which have come about in the past fifty years. I might compare myself to the little boy who

registered to start school at the age of nine. The teacher asked him if he could read or write. He answered, surprised: "Gosh no, I ain't been here but fifteen minutes!"

Well, I might say in reply to a question of my knowledge of medicine: "Gosh, I ain't practiced but fifty years!" How true it is that a single life span is but a "spit in the ocean"! Nevertheless, I am grateful that I have lived at such a time and seen such wonderful changes in the behalf of making man's life longer and less painful. The horse and buggy era in medicine has gone just as the "wonderful one-hoss shay."

You will remember the "wonderful one-hoss shay" was written by Oliver Wendell Holmes. It was built by a deacon who swore:

"He would build one shay to beat the town  
'n' the county 'n' all the country round;  
It should be so built that it couldn't break down;

"Fur," said the Deacon, "'T's mighty plain  
That the weakest place must stand the strain;  
'N' the only way to fix it, uz I maintain,

Is only jest

T'make that place uz strong uz the rest."

For a hundred years that shay lasted, right up to the day, but on that day a parson rode it and had a spill.

"What do you think the parson found,  
When he got up and stared around?

"The poor old shay in a heap or mound,  
As if it had been to mill and ground!

You see, of course, if you're not a dunce,

How it went to pieces all at once,  
All at once and nothing first—  
Just as bubbles do when they burst.  
End of the wonderful one-hoss shay.  
Logic is logic. That's all I say."

That, gentlemen, is the poem to end all poems, for it describes to a crossed "t" what happened to the wonderful horse and buggy era in medicine. We thought we stood at the peak of scientific progress; that day has passed and newer, greater changes are coming in the age of jet propulsion, or, if you like, the atomic age. Do you think for a moment the problems of today can't be licked? If you do, remember that old Benjamin Brodie was announcing that men would never find a satisfactory agent for surgical anesthesia, just at the very moment that the ship with the news of ether was on the way to England. Samuel Gross said that surgery had reached the limit of its possibilities, and he had never removed an appendix.

One thing, however, I know I can count on, the horse and buggy can never come back. The slow traveling, kitchen table surgery, unskilled help, few instruments, rough diagnosis, and unsanitary days of the past are gone for good. I know this very well, for . . .

I saw, of course, I was not a dunce,  
How it went to pieces all at once,  
All at once and nothing first . . .  
Just as bubbles do when they burst.

End of the wonderful horse and buggy day.  
Logic is logic. That's all I say."



## THE HARTFORD MEDICAL SOCIETY

EDWARD J. WHALEN, M.D., *Hartford*

WE READ in the twenty-fifth chapter of Leviticus that the Lord commanded Moses to instruct his people to celebrate the fiftieth year because that was the year of the jubilee when every man should return to his possessions and everyone shall go back to his former family. The tribe of Aaron continued this custom so we today celebrate our second jubilee according to scriptural injunction. We celebrate in a spirit of humility remembering those things in which we have failed, but with a deep sense of gratitude for the rich treasure left by those who preceded us.

Hartford one hundred years ago was a community of about thirteen thousand people who were cared for by twenty doctors, some of them of the regular order but many others wise only in the art of healing and not trained in the science of medicine. This was the age of the charlatan. The community abounded in bonesetters, herbalists, botanists, mesmerists, consumption specialists and clairvoyants, all proficient in the arts and wiles of the impostor.

In 1846, our birth year, the Farmington Canal had been completed and water flowed the eighty miles from New Haven to Northampton. The water leaked out at Southington and with it went the savings of the bold investors. This was the era of railroad building and as the water seeped out of the canal a railroad was built from New Haven to follow the course of the abandoned waterway. This year we were at war with Mexico in an attempt to gain Texas and California, an unpopular war in New England and Hartford since it threatened the addition of another slave state to the Union. In Boston, Morton a former pupil of Horace Wells was administering ether for the first time for surgical anesthesia. Samuel Christian Frederick Hahnemann had died the year before leaving to the world his child, Homeopathy, a mild well mannered child, whose very mildness infuriated the regular doctors.

With these world-shaking events taking place, the little community at Hartford remained calm

and undisturbed. Only the doctors were disturbed about many things: the lack of mutual understanding, the exploiting of the people by charlatans, and the need of scientific culture among the physicians. In an effort to correct these faults, fifteen doctors grouped together to form the Hartford Medical Society. They wrote as the preamble to their constitution: "The object of this Society is to maintain the practice of medicine and surgery in this city on a respectable footing; to expose the ignorance and resist the arts of quackery and to adopt measures for the mutual improvement, pleasant intercourse and the common good of its members." The Society met twice a month at the homes of the members and the women folk provided the food which was frequently described as, "bountiful," in the minutes.

At the meetings during the first decade of the Society, interesting cases were reported, opinions exchanged and the doctors learned to disagree without being disagreeable. This was a happy group because they were free men, living in a free country, free in the sense that D. H. Lawrence wrote: "Men are free when they are in a living homeland, not when they are straying and breaking away. Men are free when they are obeying some deep, inward voice of religious belief. Obeying from within. Men are free when they belong to a living, organic believing community, active in fulfilling some unfulfilled, perhaps unrealized purpose." They were free, unarmed, but not afraid. They had no hypodermic medication, no clinical thermometers, no knowledge of bacterial infection, no stethoscopes. They did have drugs in great numbers and of high potency in which they held an abiding faith.

1850 was the beginning of the industrial era in New England and cities like Hartford were growing rapidly. With the growth of the city, came the need of a hospital to house the sick. Urged by the doctors, generous citizens contributed twenty thousand dollars which was supplemented by a grant of ten thousand dollars from the General Assembly for the purpose of providing a hospital.

Land was purchased, buildings renovated and the Hartford Hospital was opened for the reception of patients in 1855. The founders requested the Hartford Medical Society to provide a professional staff to care for the hospital patients. The Society, in turn, agreed that each member would serve, in rotation, for a period of two weeks.

In our national life, dissensions were brewing only to come to the boiling point a few years later in the war between the States; and once again it was evident that when men stop thinking they start to fight. Many of the doctors left the city with the troops, but kept the Society informed of their activities in letters describing battle casualties, hospital gangrene and the putrefaction of wounds. It was during the war period that hypodermic medication came into general use for the first time.

In 1865, came peace and the return of the doctors. Dr. John O'Flaherty, Nathan Mayer, Melancthon Storrs, Irving Lyon and George Jarvis were among the doctors who had served in the war and now were added to the membership of the Society bringing the number of members to twenty-three. The meetings of the Society continued in the old manner with the relation of cases and a retelling of the old stories of older drugs. At a meeting in 1869, Dr. Storrs described to the Society the caecum and its appendix. He exhibited a dried specimen which had been inflated before drying, showing the ileocecal valve and the ease with which small substances might pass into the appendix. He commented, "That there would always be obscurity about the diseases of the caecum to be cleared up at the autopsy table." It remained for Reginald Fitz of Boston, seventeen years later in 1886, to clear up this obscurity at the operating table. It was in this year, 1886, that the Society welcomed a young doctor, Charles C. Beach, who came to the city with a cultural background and an uncompromising attitude toward all that was unproven in science. During his sixty years of membership in this Society, he has done much to sustain the standards so clearly described in the preamble of our constitution.

Instruments of precision and new methods were being provided for the use of doctors in the diagnosis and treatment of disease conditions. In the catalogue for 1868 of the Harvard Medical School, there is a description of the stethoscope and its use in the training of medical students. A year later, in 1869, the clinical microscope was made available to doctors and Dr. George Hawley obtained one

which later was presented to this Society. The greatest gift came from Lord Lister in 1870 with the perfecting of antiseptics and surgical asepsis. The putrefaction of wounds was now under control.

In 1895, Roentgen reported his discovery of the x-ray; and the next year the Society was invited by Trinity College to witness a demonstration of x-ray photography by Professor Robb at the Jarvis Laboratory. Also in 1896, Dr. Howe reported to the Society that in a short time the Hartford Hospital would have complete x-ray equipment for the use of doctors.

Hospital facilities had now become inadequate for this growing city and in 1897 Saint Francis Hospital was opened for the reception of patients. The growth of Saint Francis Hospital was rapid since it provided an opportunity for doctors who were not members of the older hospital staff to provide hospital care for their patients.

1900 ushered in the new century and witnessed the flowering of the Hartford Medical Society and a perfect display of the impress of personalities on a group. In the first five years of the new century, Brewster Brainard, Michael Gill, Edward Lampson, Terry Smith, Walter Steiner, Henry Stoll, Ernest Wells, Fred Willard and Orin Witter came to the city, joined the Society and brought with them youthful enthusiasm and modern medical training. Some of these young men had been trained at Johns Hopkins in those golden years of Osler, Welch, Kelly and Halsted.

Dr. O. C. Smith who had become a member in 1884 was the leader who showed the way to the younger men. A talented surgeon with a gift for leadership he was an outstanding surgical figure in Hartford when this city was the recognized surgical center of Connecticut. There were giants in those days: Smith, McKnight, Howe, Taft, Boucher and Sullivan, who were all doing the new radical and untried surgical procedures. Gathered about these surgeons were a group of younger men who were obtaining valuable surgical experience under these leaders, not learning to do but learning by doing, the newer surgical technics. These young men, Edward Lampson, Alfred Rowley, Ernest Wells and Fred Willard later were to demonstrate how valuable was surgical training under the masters.

With this intense interest in surgery it was to be expected that this group of surgeons would feel the need of closer cooperation, so in 1905 a Surgical



Section was created as a part of the Hartford Medical Society. Dr. O. C. Smith was chosen as the first chairman and Fred Willard as clerk. The Section held meetings once a month, listened to guest speakers and attracted large numbers to their meetings. It was the custom at that time for doctors to make frequent visits to medical centers and clinics so at every meeting of the Surgical Section Dr. Smith or one of the other surgeons would report on a recent trip to the Mayos, to the Crile Clinic, to Chicago and Murphy or to some European Clinic.

The parent Society continued its activity under the stimulus of these young men. In 1908, Dr. Lampson reported two successful transfusions according to the method of Crile. Tom Hepburn had joined the Society in 1910 and brought heat and light to bear on many controversial subjects. Albert Keith was elected Secretary in 1910 and his notes on the meetings are a delight to read, legible and informative. In 1910, Dr. John Carter Rowley brought in a preliminary report on the treatment of syphilis with "606" which created an interesting discussion. In 1911, Dr. E. K. Root described the sphygmomanometer, an instrument for estimating the blood pressure. Being an insurance medical examiner, he recognized the value of this instrument and its possibilities.

War came again in 1916 and 67 doctors from the Society went with the armed services. All of them returned in 1919 to take up practice in those strange years of the twenties when doctors interested themselves in the stock market, the campaigning of Al. Smith, and social reforms. It was then that we first discussed in a serious manner plans for the socializing of medicine and the discussion has continued to this day. All that saved this decade of the twenties from being a total medical loss was the announcement in September 1921 that Dr. Banting had discovered a pancreatic hormone that would control the level of sugar in the blood. Tonight in Toronto they are celebrating the 25th anniversary of the discovery of insulin.

In the thirties came bank failures, hunger, unemployment and further talk of social reforms with little accomplished against the hazards of dependency, unemployment, poverty and old age. Social reforms came slowly in this country because change is not demanded by the politically powerful. Organized medicine, which is politically powerless, has

made a sincere and unselfish effort over a period of thirty years to develop a workable plan that would provide better medical care for all the people. A workable plan has yet to be offered.

Again we were at war in 1941 and 62 members of this Society joined the armed forces and after four years all of them returned to us to add numbers and enthusiasm to our meetings. In this period the new chemotherapeutic drugs were offered to us, powerful agents that give promise of being only the beginning of even greater forces for the control of bacterial and other infections. The release of atomic energy, the result of years of study of nuclear physics and the chemistry of the elements has only given us the hideous picture of the mass killings at Hiroshima and Nagasaki. The turning loose of such elemental forces will add to the store of human happiness only when the world engages in spiritual searchings and recognizes the true relationship of man to his God and man to his fellow man.

And now we come to the end of one hundred years of medical history in a small New England community. Winston Churchill has said many quotable things, but none more pertinent than his observation that, "The longer you can look back the further you can look forward." We look back over the years not in smug complacency with our achievements but with a deep sense of gratitude to those founding fathers who accomplished so much with so little. Their professional standards were high and their ideals were only short of perfection. They had faith in the future of this Society and trust in the integrity of the members to carry on a noble tradition. They have manifested this faith by gifts to the Society of over three hundred thousand dollars—gifts made by doctors and their families in the belief that these funds would aid future Hartford doctors to better fulfill their mission.

This Society has done little to alter the trends in medical science. But it has been an integrating force that has sustained the standard of medical practice in this city on the high plane that was established by its founders. If we keep faith with those who have gone before us, this Society of three hundred and seventy doctors will continue to be a powerful factor in this city in the new days that promise to be filled with difficulties that will challenge both our scientific honesty and intellectual courage.

# CONNECTICUT STATE MEDICAL JOURNAL

*Owned and Published Monthly by The Connecticut State Medical Society*

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## EDITORIALS

### A Changing Society

"A Society," wrote John Morley, "can only pursue its normal course by means of a certain progression of changes, and (that) these changes can only be initiated by individuals or very small groups of individuals." If we consider the development of our modern industrial world, we find that it had its real beginnings in the advance of mechanical inventions during the last century. Thus it was the individuals responsible for such innovations who really initiated great changes in society which we now recognize in the modern world. This came about largely because the system of guilds under which workmen had operated for a long period of time broke down rapidly under a greatly increased demand for a type of labor which was largely unskilled. In England and in this country there existed but little real centralization of government as we know it today, and it is small wonder that labor was exploited and that factory owners were often ruthless in their methods. Power, however, is not a permanent but a shifting thing and it is always subject to abuse. Today we are witnessing an extraordinary reversal of affairs, especially in England where the power of the worker through a Labour Government is attempting to control and regulate industry. Whether this situation is to be viewed with alarm or not, it has the potentiality of being a most crucial social experiment, for nowhere on earth is there a greater inherent love of individual liberty and nowhere may government controls be changed as rapidly if the people so desire. The result of the last election in

our own country was interpreted as a protest against an unwarranted power which labor is said to have arbitrarily assumed.

It appears certain that in these various economic and social matters no simple set of rules are available for guidance. The picture is further complicated when we realize that patterns in other countries and indeed in sections of our own, are greatly influenced by such things as tradition, climate and geographical position.

American Medicine has a deep interest in these social problems because for some time it has been exposed to attempts which aim at central government control of medical practice, so-called socialized medicine. However, in its firm opposition to such proposals it should be emphasized that our profession is not as blind nor as hide-bound as some critics insolently declare. Through its own efforts American Medicine is largely responsible for a system of "State-Government medicine" in numerous fields, such as preventive medicine, psychiatry, tuberculosis, infectious disease, to mention a few, in which thousands of physicians participate, and which has become an indispensable part of our civilization. It is with absorbing interest therefore that we view the efforts of British politicians to control medical practice. The outcome may have far reaching effects on our own socio-medical relationships.

A healthy and progressive attitude of mind has recently been expressed by the president of our State Medical Society. Dr. Miller writes, "We ob-



serve an increasing tendency for organized society to arrange and control large areas of our lives. When these extensions of government are sound and in the public interest, we must, as good citizens, exert ourselves to make the operation smooth, efficient and economical."

## Where We Stand

The recently published report of the Commission on Hospital Care entitled *Hospital Care in the United States* summarizes the findings of an intensive two year survey of general hospitals. The material assembled by the commission and the recommendations make the report a valuable reference book for all those who are interested in hospital care, such as, administrators, trustees, physicians and nurses. The Commission on Hospital Care was established in 1944 by the American Hospital Association. In its list of members were representatives of hospital administration, medical and nursing education, universities, public health, the Grange, the American Federation of Labor and other groups. The purpose of the report is to act as a guide to the future development of hospital care and in this function it appears likely to be of inestimable service. Certain statistical data in the report is of pointed interest to Connecticut physicians particularly in its relation to other states. As an example we note that for the year 1944 the per capita income payment for all individuals in this country was \$1,117. For Connecticut this figure was \$1,509 only being surpassed by that of New York, \$1,519. A table of further interest shows the relation of active physicians to population. For the entire United States in the year 1943 this was one physician to every 806 individuals. For Connecticut this figure was 736 and four states are lower, Illinois, Massachusetts, New York and Vermont. Similar figures for active registered nurses (1945) showed Connecticut one nurse for 323 individuals with no states lower than this. For classified nurses in Connecticut, one for 217 with Vermont one to 188.

The average size of hospital communities (1944) shows that Connecticut has 169 square miles per hospital community. Three states have less, Massachusetts 99, New Jersey 134, Rhode Island 132. Beds per 1,000 of population (1944) shows that Connecticut stands twelfth from the top with 3.96 beds, Montana being high with 6.25 and Massachusetts second with 5.33.

A study of full time personnel per patient day (1945) shows a figure of 1.68 for Connecticut exceeded by Delaware 1.81 and Rhode Island 2.04. The percentage of births in hospitals in 1943 was 72.1 for the United States. Connecticut heads this list with 97.3 per cent with Washington second 96.3 per cent.

An interesting part of the report is concerned with the history of hospital care in this country. The voluntary hospital had its beginning in the Pennsylvania Hospital (1751). Later came the New York Hospital (1798), the Massachusetts General Hospital (1816) and the New Haven Hospital (1826).

From certain statistical points of view, therefore, our state is in a comparatively excellent position. However, this does not lessen our responsibilities or the need for careful consideration of our hospital care problems. The relatively high earning capacity of the people of our state forces a demand that they must be assured of adequate hospital care. This can be accomplished in part by insurance plans which should go forward as rapidly as possible. The part that the physician must play is obviously a crucial one.

Book Review: *Hospital Care in the United States*, Conn. State Med. Jour., Oct. 1947, page 880.

## The National Blood Program

The National Blood Program which the American Red Cross is undertaking is one of the most far reaching peacetime projects in the history of the organization. In essence the program will provide whole blood and its derivations to the entire nation without charge for the products. In embarking on this program the Red Cross will work in close relationship with the medical profession, and health authorities, and local operations will be undertaken only with the support of local health departments and medical societies. It is estimated that from three to five years will be required before the program is in full operation. In addition to whole blood and plasma the National Blood Program will provide other blood derivatives of proved value, such as Serum Albumin, Immune Serum Globulin, Anti-hemophilic Globulin, Blood Grouping Serum, Fibrin Films and Thrombin, Red Cell Suspensions, Red Cell Paste and Powder. Other blood derivatives that continuing research may find useful will be made available. Blood and blood products will be provided without charge to patients, physicians,

hospitals, the only charge ever made to the patient being that of professional services in administering the material.

Blood programs already established may well be integrated with the National Blood Program. In this way full benefits from the fractional phase of the project will be available to those communities in which only whole blood or plasma is being provided.

### Functional Disorders

Two recent articles<sup>1,2</sup> point up the need for wider clinical recognition of functional disorders. They are said to be the greatest single cause of the symptoms which bring patients to doctors' offices. It is claimed that they now are too often unrecognized. To remedy the situation concerted effort is urged by medical schools, general practitioners, psychiatrists and specialists in the preclinical sciences. It is suggested that the medical student be given from the first week in school the opportunity to study all of man, not only the somatic half.

This challenge obviously ought to be met but instead of relying upon students to meet it, it should be put squarely up to established clinicians and specialists in the various branches whose positions enable them to lead the thoughts and to direct the methods of both general practitioners and students. Waiting for students and children to bring about a millenium is an unrealistic dodge on the part of adults. It is unreasonable to expect students to carry over from school the necessary impetus to overcome the predominantly somatic approach of hospital seniors and service chiefs. Most young physicians develop along lines laid down by those who, formally or informally, are their preceptors and whose attitudes towards functional disorders will be reflected in their juniors.

Reliance upon the next generation to right the wrongs of the present may result from sloth or thoughtlessness. In either event it is likely to fail as are most attempts to pass the buck. The achievement of understanding and the application of a broader acceptance of functional disorders must begin now, not tomorrow. The way must be shown by the present generation of clinicians and the next group will naturally take the further steps as they come along.

1. Functional Disease, Joseph T. Wearn: J. of The A.M.A. 134. 18.

2. Psychomatics, Edward A. Strecker: J. of The A.M.A. 134. 18.

### Population Gain

There are 300,000 more people in Connecticut than there were in 1940 according to estimates of the Census Bureau. The estimated population of the state is 2,042,000, a gain of 19.4 per cent in seven years.

The increase in population for the country as a whole was 8.7 per cent, Connecticut more than doubled the average gain and only Maryland, among the eastern states, showed greater increase. The current rapid gain in Connecticut becomes more striking when it is noted that during the census decade 1930 to 1940, the state showed a population increase of only 100,000.

Connecticut had, as might be expected, a substantial gain during the war, but the Census Bureau shows that this gain has been extended in the post-war period. Only six states show war and postwar gain, Connecticut, Indiana, Arizona, Michigan, Maryland and Oregon. As a result of this increase, Connecticut becomes one of the most densely populated among the states with approximately 400 people per square mile. This concentration of population is exceeded only by Rhode Island, Massachusetts and New Jersey.

The extraordinary increase in the number of people in the state is of great significance to medicine and to all others interested in providing medical care. It means an increased demand for services and personnel, for hospital beds, and for the extension of public health programs. Planning that might have been adequate in 1940 will no longer suffice.

### Spotting the Tuberculosis Individual

Almost since the discovery of the tubercle bacillus in 1882 vital statistics from the United States have shown a steady decline in the tuberculosis death rate. Fifty years ago this rate was 194 per 100,000 population. In 1910 the rate had dropped to 153.8 and in 1944 to 41.3. The vital statistics records of fifty years ago were arrived at in the presence of many inaccuracies in clinical diagnosis so that the high rate recorded for tuberculosis in that era may be questioned today. Postmortem records were few in number and the laboratory diagnosis of tuberculosis extremely crude.

Certain features of this problem as it now exists are disturbing. As pointed out by a pathologist in a recent issue of the *Bulletin of the National Tuberculosis Association*, tuberculosis is still the chief



cause of death, except for accidents, in the fifteen to thirty-four years of age group, and also in recent years the tuberculosis death rate in old persons has shown an increase. The overall tuberculosis death rate in some of our possessions is likewise a cause for alarm, with Alaska recording a rate of 362.2 per 100,000 persons and Puerto Rico one of 215.

Many hospitals now are requiring routine chest roentgenograms of all admissions and have found many cases of tuberculosis in the hospital wards who enter for unrelated complaints. These patients may be in the hospital for long periods without their tuberculosis being discovered and thus present a source of infection to the nursing staff.

At the Meyer Memorial Hospital in Buffalo, New York, the most satisfactory method has been found to be the making of a set of 4 x 5 inch miniature chest radiograms on a 4 x 10 inch film. The standard 14 x 17 inch chest film was found to be too expensive and too difficult to process and handle and the 35 mm. film gave less accurate results.

It must be borne in mind, however, as pointed out by the pathologist referred to above, that a single roentgenogram of the chest can reveal only what is detectable at the moment and that the very early pathological process is never seen in an x-ray film. X-ray shadows cannot tell the exact condition of the tuberculosis process, whether it is really healed or not. It is only from repeated examinations that the stability and not the pathological healing can be determined.

A Pathologist Looks at TB, E. M. Medlar: Bull. Nat. Tb. Assoc., Jan. 1947.

Routine Chest Roentgenograms of Hospital Admissions, G. B. Scatchard and D. A. Duszynski: Dis. of Chest, XIII 4.

## Anesthesia Study Commission

An Anesthesia Study Commission has been unanimously approved by the members of the Section on Anesthesia to constitute a very active part of our Society functions. The purpose of this Commission is essentially to discuss all operating room deaths and major anesthetic complications that are brought to the attention of the Commission. Hospital and patient names, of course, will not be mentioned but coded. Through such discussions it is hoped that anesthetic morbidity and mortality in this state will be eliminated or decreased to an irreducible minimum.

The following members have been appointed to

serve on this Commission: Carl Hellijas, Hartford Hospital; Stevens J. Martin, St. Francis Hospital; Ralph Tovell, Hartford Hospital; and Leopold Trifari, St. Frances Hospital.

Complete case reports should be submitted to the office of Stevens J. Martin, president, Section on Anesthesia, to include not only the preoperative status, anesthetic management, and postoperative course of the patients, but also all pertinent laboratory data and autopsy findings, if available.

## Tennessee Program for Registered Practical Nurses

The Tennessee Nurses Association secured from the 1945 General Assembly of the State authority to grant licenses and register practical nurses. The resultant training program for practical nurses as organized in that State consists of three major phases: (1) twelve weeks of special in-school training consisting of five six-hour days or thirty hours per week; six months of on-the-job training in co-operating hospitals; three additional months of on-the-job training experience in convalescent hospitals, homes for the aged, and private home practice: Following these months of training the student must pass an examination by the State Board of Nursing Examiners.

The entire year's training program for practical nurses is conducted as a part of the Vocational Education program of the respective local Board of Education. Applications for enrollment in the new classes which began recently far exceeded the accommodations afforded for this program. Tennessee is one of the leaders in meeting the need for more nurses.

## State Journals Grow

*The Rocky Mountain Medical Journal* has announced with justifiable pride that, effective January 1, 1948, the Montana State Medical Association will become one of that *Journal's* official sponsors. At present the *Rocky Mountain Medical Journal* represents the societies of Colorado, New Mexico, Utah and Wyoming.

From the Dakotas comes the announcement that these two State societies are planning to publish their own journal.

Connecticut offers its congratulations to Montana, to North Dakota and to South Dakota.

## THE PRESIDENT'S PAGE

The midyear meeting of the House of Delegates will have before it the report of the Committee on Prepaid Medical Care. This report carries out the instructions of the House of Delegates to develop a voluntary prepayment program utilizing the cash indemnity systems of private insurance carriers.

The Society has determined that the usual relations between physician and patient must be preserved, and that this can be done while guaranteeing definite benefits for specified services. This program will begin with benefits for surgical and obstetrical care and will provide indemnity for anesthesia when billed by a licensed physician.

The House of Delegates will be asked to determine an appropriate income level for the individual and for the family below which members of the Society will engage to render a specific service for no more than the specified indemnity. According to the program this will be done provided (1) the patient certifies that his income is below the required level; and (2) that he assigns his benefits under the policy for payment direct to the physician.

This prepayment program marks a good beginning in bringing the insurance principle to bear on an important need: namely, to make available to the people of Connecticut protection against the costs of medical care at an amount they can afford to pay. Our negotiations in preparing this plan have convinced us that the insurance industry is willing and is now ready to play its part.

James R. Miller



## FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET

NEW HAVEN

## CALL

## SEMI-ANNUAL MEETING OF THE HOUSE OF DELEGATES

The 1947 semi-annual meeting of the House of Delegates will be held at the New Haven Medical Association, 364 Whitney Avenue, New Haven, on Thursday, December 4, beginning at 3:30 in the afternoon.

James R. Miller, President  
Creighton Barker, Secretary

## THE HOUSE OF DELEGATES

The President, James R. Miller, Hartford

The President-elect, Samuel C. Harvey, New Haven

The Treasurer, Cole B. Gibson, Meriden

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Delegates to the American Medical Association,

Thomas P. Murdock, Meriden and

Joseph H. Howard, Bridgeport

Editor of the Journal, Stanley B. Weld, Hartford

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C. Charles Burlingame, Hartford

Floyd A. Weed, Litchfield

Harold E. Speight, Middlesex

Herbert Thoms, New Haven

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Charles T. LaMoure, Tolland

Karl T. Phillips, Windham

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George R. Cody, South Norwalk

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Waldo F. Desmond, Newtown

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John G. Frothingham, New Canaan

James Douglas Gold, Bridgeport

James V. Halloran, Greenwich

Kirby S. Howlett, Jr., Shelton

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Eugene F. Meschter, Stamford

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Morris P. Pitcock, Bridgeport

Arthur C. Smith, Danbury

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Ettore F. Carniglia, Hartford

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James R. Cullen, Hartford

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Augustus R. Felty, Hartford

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## Middlesex County

Norman E. Gissler, Middletown

Thomas E. Horsefield, East Haddam

Lloyd W. Minor, Middletown

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Donald M. Beckwith, East Haven

Courtney C. Bishop, New Haven

Dana L. Blanchard, Branford

Charles A. Breck, Wallingford

Herbert J. Corbett, Waterbury

A. Nowell Creadick, New Haven

Simon D. Doff, New Haven

William Finkelstein, Waterbury

John H. Foster, Waterbury

Samuel J. Goldberg, Jr., New Haven

William E. Hall, Meriden

Andrew J. Jackson, Waterbury  
 Stephen L. Lirot, Meriden  
 Ralph E. McDonnell, New Haven  
 M. Heminway Merriman, Waterbury  
 Samuel B. Rentsch, Derby  
 Walter I. Russell, New Haven  
 Charles I. Solomon, Meriden  
 Thomas J. Sullivan, New Haven

#### New London County

Mario J. Albamonti, Norwich  
 Charles G. Barnum, Groton  
 Casimer E. Bielecki, Norwich  
 Thomas Soltz, New London

#### Tolland County

Wendelin G. Luckner, Stafford Springs

#### Windham County

Cecil R. Carcin, Danielson  
 Brae Rafferty, Willimantic

#### COUNCIL RESUMES REGULAR MONTHLY MEETINGS

The first fall Council meeting after the summer recess was held on October 3 at the offices of the Society. There were present: Drs. Murdock, Weed, LaMoure, Miller, Parmelee, Thoms, Speight, Howard, Burlingame, Barker, Miss Mooney and Dr. Frank Couch, Cromwell, who was a guest observer from the Committee of Sixteen. Absent: Drs. Weld, Gibson, Gildersleeve, Harvey, Phillips. Among items of business considered were:

#### DETECTION CENTER POLICY

Acting on a request from the Connecticut Cancer Society, the Council discussed at length the purposes, promotion and publicity policies for detection centers. It was voted that a committee of three be appointed to set up standards and policies for the guidance of detection centers to be operated under the auspices of the Cancer Society.

#### SECTION ON AVIATION MEDICINE

Favorable action was taken on the request from a number of members for permission to organize a Section on Aviation Medicine.

#### 1947 CLINICAL CONGRESS

It was reported to the Council that there were 615 registrants at the 1947 Clinical Congress of which 439 were members of the Society and 176 were non members.

#### COMMITTEE REPORTS

The Council voted to request the Committee on Workmen's Compensation Laws, Committee to Study the Organization and Objectives of the

Society, Board of Trustees of the Building Fund and the Committee on Prepaid Medical Service to present interim reports at the Semi-Annual Meeting of the House of Delegates on December 4.

#### 1948 ANNUAL MEETING

Holding the 1948 Annual Meeting of the Society at the Roger Ludlowe High School, Fairfield, on April 28, 29 and the Annual Meeting of the House of Delegates on April 27 was approved.

#### ADVISORY MENTAL HEALTH COMMITTEE

Dr. Burlingame and Dr. Barker were named a committee to select three or four psychiatrists to be recommended to the State Department of Health for appointment on the State Advisory Mental Health Committee as provided by Public Act 233.

#### JOINT COMMITTEE TO STUDY REVISION OF COMMITMENT LAWS

On invitation of the Joint Committee of Mental Hospitals, the Council appointed Dr. Edward L. Brennan of Hartford to represent the Society on a Joint Committee of Mental Hospitals to study the revision of commitment laws.

#### DR. GANDY RESIGNS

The Council accepted with regret the resignation of Raymond A. Gandy as a member of the Board of Trustees of the Building Fund. Dr. Gandy's successor will be named later.

#### RADIO APPROVAL

The Council approved the Society's participation and sponsorship of the Yankee Network radio program "Doctors' Orders."

#### CONNECTICUT NUTRITIONAL COUNCIL

Dr. James R. Miller, Dr. David Gaberman, both of Hartford, and Dr. Max Caplan, Meriden, were named as delegates from the Society to the organizational meeting of the Connecticut Nutritional Council.

### Meetings Held During October

Thursday, October 2, 3:00 P. M.  
 Committee on Public Health

Friday, October 3, 4:00 P. M.  
 Council of the Society

Monday, October 6, 5:00 P. M.  
 Committee on Cooperation with the Yale School of Medicine, Graduates Club, New Haven



Wednesday, October 22, 4:00 P. M.

Committee to Study Maternal Morbidity and Mortality

7:00 P. M.

Committee on Industrial Health

Friday, October 24, 4:00 P. M.

Program Committee, 789 Howard Avenue, New Haven

Saturday, October 25, 5:30 P. M.

Committee to Study the Workmen's Compensation Law

### Meetings Scheduled for November

Monday, November 3, 4:30 P. M.

Council of the Society

Wednesday, November 12

Written examinations of the Connecticut Medical Examining Board, Hartford

Thursday, November 13

Written examinations of the Connecticut Medical Examining Board, Hartford

4:00 P. M.

Committee on Rural Medical Service

Tuesday, November 25

Executive meeting, Connecticut Medical Examining Board

### Progress of Prepayment Plans

The Council on Medical Service of the AMA reports that mid-year enrollment in voluntary prepayment medical care plans is safely past the six million mark. Countrywide, this represents enrollment growth at the rate of approximately 200,000 new subscribers per month. The range of percentage increases for the six month period was from 4.9 to 763.2 with an overall average of 31 per cent.

Eighteen of the voluntary prepayment medical care plans reported a June 30 enrollment of more than 100,000 each. Four of them reported enrollment in excess of 500,000.

The Life Insurance Association of America conducted a recent survey of group health and accident insurance (including hospitalization and medical expense benefits) in force at the end of 1946. This survey showed substantial gains in this field.

Of interest to the medical profession is the recent Council approval of simplified disability claim blanks to be used by insurance companies when requesting medical information.

### Dr. Moorad on Seminar Committee



PHILIP J. MOORAD, M.D.

Philip J. Moorad, neuropsychiatrist at the New Britain General Hospital, represents the State Medical Society on the executive committee of the Connecticut Postgraduate Seminar of Neuropsychiatry which began its sessions on September 26 at the Connecticut State Hospital in Middletown.

Sponsored by the Department of Psychiatry and Mental Hygiene, Yale University School of Medicine, and the Joint Committee of the State Mental Hospitals, the seminar will continue through April 26, 1948. Sessions will be held each Monday, from 2:00 to 4:00 P. M., 5:00 to 7:00 P. M., and 8:00 to 10:00 P. M. Additional sessions will be held on Wednesdays, December 10, 1947, March 24, 1948, and April 21, 1948, at the same hours.

The seminar will recess from December 11, 1947 to January 5, 1948. All sessions up to and including January 26, 1948, will be held at the State Hospital in Middletown. From February 2, 1948, through April 26, 1948, sessions will be held at the Department of Psychiatry, Yale School of Medicine, Room 305, 333 Cedar Street, New Haven.

The curriculum of the seminar will consist of

review and orientation lectures in subjects relevant to the study and practice of neuropsychiatry, and will be divided into five periods, as follows: Review of Basic Disciplines of Neurology and Related Subjects, thirty-six lectures; Review of Topics of Clinical Neurology Applied to Psychiatric Practice, twelve lectures; Clinical and Social Psychiatry, Applied Psychology, and Sociology, twenty-seven lectures; Review of Therapy in Psychiatry, nine lectures; and Review of Pediatric Neuropsychiatry, nine lectures.

Other members of the seminar committee are Edgar C. Yerbury, M.D., superintendent, Connecticut State Hospital, Middletown; Frederick C. Redlich, M.D., Department of Psychiatry, Yale University School of Medicine; Clements C. Fry, M.D., Department of University Health, Yale University School of Medicine; and Paul I. Yakovlev, M.D., director of research and training, Connecticut State Hospital, Middletown. Inquiries regarding the seminar may be addressed to Dr. Yakovlev, curricular secretary, at the Department of Psychiatry, Yale University School of Medicine, Room 328, 333 Cedar Street, New Haven.

### Dr. Alice Hamilton Honored

Alice Hamilton, M.D., seventy-eight, of Hadlyme, who has devoted her career to the prevention of occupational diseases, was presented with one of the seven Lasker Awards of the American Public Health Association at its seventy-fifth annual meeting held on October 9 in Atlantic City.

Given in recognition of her work as "an eminent medical scientist," the award includes a citation, a gold statuette, and \$1,000 in cash.

Born in New York City, Dr. Hamilton attended Miss Porter's School, in Farmington, the University of Michigan, the University of Leipzig, the University of Munich, and Johns Hopkins University. Four other American universities have awarded her

### Talk With Your Representatives

During the congressional recess most members of Congress are at home. Don't overlook the opportunity of talking with your representative on pending health legislation. For example, there are two bills—S1714 to provide for maternal and child health and S1734 to provide for national unemployment and temporary disability insurance—which are worth more than passing attention. (See page 1551, August 30, 1947 issue of J.A.M.A.)

If you read the preambles of these two bills, you will notice that they represent more social legislation along the same line as the Wagner-Murray-Dingell bills. A digest of the bills would lead one to believe that "the American people are really in a poor way."

honorary degrees, and in 1942 the State Medical Society presented her with an honorary degree at its annual meeting of that year.

Teaching at the Northwestern University Medical School for Women, in Chicago, from 1897 to 1905, and pursuing research work in occupational diseases from 1905 to 1910, she later became a special investigator for the U. S. Department of Labor, from 1911 to 1921. Other teaching posts held by Dr. Hamilton included that of assistant professor of industrial medicine at Harvard Medical School. A member of the League of Nations Health Commission from 1924 to 1930, she has also been active in national health groups, and was engaged by the Department of Labor for several years prior to 1939 to investigate health dangers in the manufacture of viscose rayon. She is the author of numerous books, pamphlets, and magazine articles on occupational medicine.

## THESE GAVE

### CONTRIBUTORS TO THE BUILDING FUND, SEPTEMBER 15 - OCTOBER 10

#### HARTFORD COUNTY

Gray, Harry J., Hartford  
LoVetere, Angelo, New Britain  
Reidy, D. Dillon, Hartford  
Tirella, Fred F., Bristol

#### NEW HAVEN COUNTY

Brody, Bernard S., New Haven  
(additional contribution)  
Fuldner, Russell V., New Haven  
Smith, Fred F., New Haven  
Solomon, Charles I., Meriden

#### FAIRFIELD COUNTY

Monahan, David T., Bridgeport  
White, Ralph L., New Canaan



## Alcoholics Now Treated in Connecticut

Inauguration of group therapy treatment for alcoholism is announced by Edward J. McDermott, executive director of "Easy Acres" at Newtown, the only licensed private establishment in Connecticut working solely with alcoholic patients. Conducting the treatments is Francis Paul, M.D., medical director, a diplomate of the American Board of Psychiatry and Neurology and a Fellow of the American Psychiatric Association, who for the past twenty years has devoted his medical practice exclusively to the problems of psychiatry.

In addition to his private practice and duties at Easy Acres, Dr. Paul is at present attending psychiatrist at Norwalk General hospital and is engaged by the Veterans' Administration to give psychiatric treatment to veterans for service connected disabilities. He also assists in psychiatric rehabilitation of patients under the sponsorship of the State Department of Education, Division of Rehabilitation.

In defining the group therapy method in use at Easy Acres, Dr. Paul says, "In substance this type of treatment means that people with similar problems get together and discuss those problems that are common to all. Experience has shown that many persons who are reluctant to discuss their difficulties in a personal interview are apt to lose their shyness when they are in a group and become aware that others have quite similar problems. This awareness not only helps them to overcome their shyness to the extent that they participate actively in the discussions, but also they are willing to follow up with personal talks with the psychiatrist.

"The aim of the psychiatrist in group sessions is to encourage the participants to reveal factors in their personality problems, to interpret them and to suggest a constructive approach toward readjustment. The patients are made conscious of the importance of their personal initiative and active participation in the solution of their problems."

Besides psychiatric advice, patients at Easy Acres are offered two other aids to proper readjustment. Primarily, upon admission to the establishment, immediate medical treatment is concentrated upon correction of the physical effects of excessive drinking. Dr. Francis P. A. Williams of Stepney, is attending physician and the staff includes registered nurses and trained attendants. After receiving his B.S. degree from Harvard, Dr. Williams took his M.D. at the New York Medical College-Flower

Fifth Avenue hospital. He interned at Bridgeport hospital and during the war was senior medical officer, 19th Fleet, San Diego group. He is now a member of the staff of Bridgeport hospital.

Supplementing professional medical and psychiatric care also is association with Alcoholics Anonymous, available for those wishing to pursue the course of lay therapy advised by that nationally known organization. "AA" meetings, with guest speakers, are held on the premises each week. A library of information on the subject of alcoholism is also available for the use of patients.

Prior to the opening of Easy Acres, Director McDermott owned and operated a rest home for alcoholics at Oxford. He also made an intensive study of the problems of the alcoholic at the Yale University Summer Course in Alcohol Studies and at the Institution on Alcoholism, sponsored by the Connecticut chapter of the American Association of Social Workers and the Section on Alcohol Studies of the Yale Laboratory of Applied Physiology.

Concluding that a combination of physiological and psychiatric treatment and lay therapy was needed to enable the alcoholic to readjust himself, he decided to establish the present set-up at Easy Acres. Housed in a remodeled and thoroughly modernized inn on Castle Hill road, the Newtown rehabilitation center provides an informal and congenial atmosphere for patients during the period of treatment. Medical facilities were designed to meet in full the license requirements of Connecticut.

## Rehabilitation Services Provided by State

John J. Dobkins, recently appointed chief medical consultant for the Division of Rehabilitation, State Department of Education, invites the attention of all Connecticut physicians to the booklet "The Doctor and Vocational Rehabilitation for Civilians."

A new publication of the Office of Vocational Rehabilitation of the Federal Security Agency, the booklet has been mailed to all practicing physicians.

In a letter concerning the functions of the State Division of Rehabilitation, Dr. Dobkins explains that its services are available for patients suffering from physical or mental ailments which constitute employment handicaps. These services include (1) vocational guidance, to help the patient adjust to working conditions despite his disability; (2) vocational training, where disability prevents the patient from resuming his former occupation and it

is necessary for him to learn new skills; and (3) physical restoration, where the disability can be materially lessened or removed by medical or surgical treatment, physical or occupational therapy, or prosthetic appliances.

The Division of Rehabilitation will provide complete diagnostic services without cost to the patient, beginning with a general examination of the patient by his own physician, and, when necessary, consultations with specialists, x-rays, and laboratory studies. If the patient cannot bear the financial burden of the treatment recommended, the rehabilitation agency will assume such obligation, it is explained.

The following cases are cited in explanation:

1. C. S., a sixty-year-old paintshop proprietor, who had a right mid-thigh amputation for diabetic gangrene, was provided physiotherapy to prepare the stump, then an artificial limb and training in the use of it.

2. R. S., a girl of thirty who had a spina bifida with meningocele operated on and had residual paralysis of both lower extremities, was trained to do clerical work and placed in a part-time job paying twice her previous earnings in work unsuitable and harmful to her.

3. N. B., a young man with marked hearing loss, was provided a satisfactory hearing aid and trained as a machine operator in a factory.

4. L. J., a twenty-year-old girl with rheumatic heart disease, was provided a course of college training with tuition and maintenance paid so that she could do work well within her physical capacities.

Dr. Dobkins points out that the Division cannot undertake general medical care, but can provide medical services only as a part of vocational rehabilitation. It is emphasized that only those cases can be treated in which disability is static or slowly progressive and where objective results can be obtained within a ninety-day period of hospitalization.

Conditions which can be accepted for treatment include: amputations, arthritis, back aches, bronchial asthma, bronchiectasis, diabetes mellitus, hemiplegia, hernia, multiple sclerosis residuals, osteomyelitis residuals, psychoneurosis, ruptured intervertebral disk, poliomyelitis residuals, stammering, and visual defects.

District offices of the Division of Rehabilitation have been established as follows: 1211 Fairfield

Avenue, Bridgeport, telephone: 6:1835; 54 Church Street, Hartford, 7-1872; 5 Jefferson Street, New Haven, 7-0195; 257 Main Street, Norwich, 4730; 36 North Main Street, Waterbury, 4-0688.

### New Emergency Commitment Form

The Emergency Certificate form supplied by the State Department of Health has been revised as a result of changes in the emergency commitment statute which became effective October 1, 1947. You will find the statute printed in full on the back of the Emergency Certificate form.

Your attention is called to the following points which the physician should be familiar with in using this method of commitment:

1. The statute no longer requires that the person to be certified be "suddenly and violently" mentally ill.

2. The Emergency Certificate must be signed by a physician licensed to practice medicine and surgery in Connecticut.

3. The signature no longer has to be sworn to as was formerly the case.

4. The signature of the physician must be dated not more than three days prior to the day of delivery of the patient to a mental hospital.

5. The examination of the patient must have been made not more than three days prior to the date of signature of the certificate.

6. The physician must state his findings relative to the physical and mental condition of the patient.

7. Every patient to be committed under this procedure has the right to call a physician of their own choice, and if this physician is of the opinion that the patient is not mentally ill, then the emergency certificate may not be used as a means of temporary detention of the patient in a mental hospital.

### Occupational Accidents in Connecticut

Connecticut workers suffered ten fatalities and 242 amputations as the result of occupational accidents during the first six months of 1947, according to a report published by the State Department of Labor.

There were 10,085 accidents during the period, a 6.5 per cent increase over the 9,429 accidents reported for the first six months of 1946. Remarking upon the increase, the report states: "Many of the lessons in safe production learned during the war



period are apparently passing into the limbo of oblivion, and relaxation of safety efforts is increasingly being noted." However, it is observed that "large establishments, realizing that efficient production means safe production, are integrating safety into their operations." It is further pointed out that "The answers to the accident prevention problem centers in the smaller plant."

Of the total number of accidents for the half-year period, manufacturing accounted for 6,281, while 3,804 accidents occurred in non manufacturing occupations. Accidents resulting in amputations totalled 216 for manufacturing, and 26 for non manufacturing, while the leading cause of accidents in all occupations, 2,715 of the total number, was reported to be "handling of objects." The second largest category, "fall of persons," accounted for 1,884 accidents, with "use of machinery" ranking as the third causative factor, 1,139 accidents.

### AMA Exhibits at Cleveland Meeting

At the AMA supplemental session in Cleveland, January 5-8, 1948, the technical and scientific exhibits will be open during the full four days of the meeting.

Since the meeting on Monday and Tuesday will be devoted largely to industrial health, that subject will be well represented so far as the scientific exhibits are concerned. Other subjects which will be emphasized are cancer, heart disease, first aid in motor accidents, diabetes, hearing aids, dermatology in general practice, endocrine diseases and nutrition. There will be several question and answer conference rooms for the benefit of physicians who are seeking specific information. Motion pictures will be shown continuously throughout the week in an area adjoining the exhibits.

No medals or certificates for exhibits will be awarded at the Cleveland session.

Dr. Dwight H. Murray, Napa, California, has been appointed chairman of the Committee on Scientific Exhibit to replace Dr. Louis H. Bauer, Hempstead, N. Y., who has been appointed to the executive committee of the Board of Trustees. The other two members of the Committee on Scientific Exhibit are Dr. James R. Miller, Hartford, Conn., and Dr. E. J. McCormick, Toledo, both members of the Board of Trustees.

### Panel Discussion on Mental Health

William B. Terhune, medical director of Silver Hill Foundation, New Canaan, will be chairman of a panel discussion on "New Developments in Mental Health Programs" to be held during the 37th Annual Connecticut Conference of Social Work, November 13 and 14, in Waterbury.

The discussion is scheduled for Thursday, November 13, from 2:00 to 4:30 P. M. The participants and their subjects will be: Edgar Yerbury, M.D., superintendent of the Connecticut State Hospital, Middletown, "Recent Advances in the State Hospital Program for Mental Illnesses;" Arthur H. Jackson, M.D., Waterbury, clinical assistant professor of neurology, Yale University School of Medicine, and attending neuropsychiatrist, Waterbury Hospital, "Psychiatry in the General Hospital;" Charles F. Von Salzen, M.D., neuropsychiatrist, Institute of Living, Hartford, "Psychiatry in the Private Hospital;" Philip B. Moorad, M.D., New Britain, neuropsychiatrist, New Britain General Hospital, "Psychiatry in Industry;" Miss Dorothy Wilson, senior mental hygienist, Connecticut State Department of Health, "The State Program for Mental Health."

A question and discussion period will follow the speakers' program.

### Dr. Klumpp Head of New Company

Theodore G. Klumpp, M.D., a member of this Society, has been elected president of the newly formed Winthrop-Stearns, Inc., a new subsidiary of Sterling Drug, Inc. President of Winthrop Chemical Company since he joined the Sterling organization six years ago, Dr. Klumpp was formerly chief of the Drug Division, U. S. Food and Drug Administration; secretary of the Council on Pharmacy and Chemistry, American Medical Association; adjunct clinical professor of medicine at George Washington University and instructor at the Yale University Medical School. Graduate of Princeton (B.S.) and Harvard Medical School (M.D.), he is chairman of the board of governors, National Vitamin Foundation, and director of the American Foundation for Tropical Medicine and of the American Pharmaceutical Manufacturers Association.

## CONNECTICUT CANCER SOCIETY

### Cancer Society to Relocate State Headquarters

At their annual meeting in Meriden, Wednesday, October 1, the trustees and incorporators of the Connecticut Cancer Society voted to name New Haven as permanent headquarters for the organization.

Heretofore the state office of the society has been located in Waterbury and only the annual cancer fund campaign administered from offices in New Haven.

The decision to relocate the headquarters followed a survey by a special committee appointed at the last annual meeting of the society. Headed by Professor Ira V. Hiscock, Department of Public Health, Yale University, the committee recommended that the state headquarters be moved from Waterbury to either New Haven or Hartford.

Delegates at the meeting also approved an amendment to the by-laws establishing a Social Service Committee. The new unit will cooperate with the organization's Medical Advisory Committee and Executive Committee to extend projects dealing with services to patients other than medical service. The Social Service Committee will be composed of eight members, at least one of whom will be a member of the Medical Advisory Committee.

In a statement following the meeting, Dr. Creighton Barker, president of the Society, portrayed the establishment of the new committee as "a step of vital significance."

"Both the local cancer groups and the state society must continue to intensify activity that will alleviate the immediate personal and domestic problems of the cancer patient. We cannot dedicate ourselves to anything more important," he said.

It was also voted to establish a campaign executive committee, and Harry F. Morse of New London, chairman of the 1947 fund campaign, was named chairman of the new group. He announced the willingness of the following to serve as members of the committee: Edward Allen, Mayor of Hartford; Frederick U. Conard, Hartford; Samuel W. Meek, Greenwich; Jesse W. Randall, Hartford;

William Rich, Wallingford; Donald Sammis, Hartford; Herman Steinkraus, Bridgeport. Dr. Barker and Richard B. Valentine, chairman of the 1948 campaign, will serve as ex-officio members.

Also confirmed was the appointment of Mrs. Douglass O. Burnham, Woodbury, as chairman of the state field army, and the appointment of Dr. Charles C. Wilson, New Haven, as chairman of the public education committee.

The executive committee of the Connecticut Cancer Society has given general approval to grants for the coming year totalling \$162,500, as recommended by the organization's Medical Advisory Committee.

In approving the grants, the committee pointed out that increasing requests for services to patients could, if allowed, absorb all of the funds raised in Connecticut. The committee cautions that such requests, while of strong humanitarian appeal, cannot properly precede requests for grants intended to benefit large numbers of patients through research and early diagnosis.

Charles C. Wilson, M.D., of Yale University Department of Public Health has accepted the invitation of the Executive Committee to serve as chairman of the Society's Public Education Committee during the coming year.

Andrew J. Jackson, M.D., and Joseph O. Collins, M.D., will serve as clinic chairmen of the Waterbury branch.

### Criticism of New Zealand's State Medical Service

A very cogent argument against the State Medical Service now operating in New Zealand may be found in a letter printed in a recent issue of *The British Medical Journal*. We quote:

"A common objection is that a young practitioner without much ability can earn a good salary so soon that he has no incentive to specialize. . . . Moreover the system does not discriminate between men of superior and inferior qualities. The general opinion is that our best medical practitioners will tend to leave New Zealand to an even greater extent than before."



## METOPON HYDROCHLORIDE

### (Methyldihydromorphinone hydrochloride)

IN 1929 with the funds provided by the Rockefeller Foundation the National Research Council, through its Committee on Drug Addiction, undertook a coordinated program to study drug addiction and search for a non addicting analgesic comparable to morphine. The principal participating organizations were the Universities of Virginia and Michigan, the United States Public Health Service, the Treasury Department's Bureau of Narcotics, and the Health Department of the State of Massachusetts, which brought together chemical, pharmacological and clinical facilities for the purposes of the study. Metopon is one of the many compounds made and studied in this coordinated effort.

Chemically Metopon is a morphine derivative; pharmacologically it is qualitatively like morphine even to the properties of tolerance and addiction liability. Chemically Metopon differs from morphine in three particulars: one double bond of the phenanthrene nucleus has been reduced by hydrogenation; the alcoholic hydroxyl has been replaced by oxygen; and a new substituent, a methyl group has been attached to the phenanthrene nucleus. Studies made thus far indicate that pharmacologically Metopon differs from morphine quantitatively in all of its important actions: its analgesic effectiveness is at least double and its duration of action is about equal to that of morphine; it is nearly devoid of emetic action; tolerance to it appears to develop more slowly and to disappear more quickly and physical dependence builds up more slowly than with morphine; therapeutic analgesic doses produce little or no respiratory depression and much less mental dullness than does morphine; and it is relatively highly effective by oral administration.

In addition to animal experiments these differences have been established by extensive employment of the drug in two types of patients, individuals addicted to morphine, and others (terminal malignancies) needing prolonged pain relief but without previous opiate experience. In morphine addicts Metopon appears only partially to prevent the impending signs of physical and psychical dependence. In terminal malignancy, administered orally, it gives adequate pain relief, with very little mental

dulling, without nausea or vomiting and with slow development of tolerance and dependence.

The high analgesic effectiveness of oral doses (with the elimination of the disadvantage to the patient of hypodermic injection), the absence of nausea and vomiting even in patients who vomit with morphine or other derivatives, the absence of mental dullness and the slow development of tolerance and dependence place Metopon in a class by itself for the treatment of the chronic suffering of malignancies, and it is for that purpose exclusively that it is being manufactured and marketed.

Metopon will be available *only* in capsule form *for oral administration*. The capsules will be put up in bottles of 100 and each capsule will contain 3.0 mgm. of Metopon hydrochloride. They can be obtained by physicians only from Sharp and Dohme or Parke, Davis & Co., on a regular official Narcotics Order Form, which must be accompanied by a signed statement supplying information as to the number of patients to be treated and the diagnosis on each. The drug will be distributed for *no other purpose* than oral administration for chronic pain relief in cancer cases.

The dose of Metopon hydrochloride is 6.0 to 9.0 mgm. (2 or 3 capsules), *to be repeated only on recurrence of pain*, avoiding regular by-the-clock administration. As with morphine, it is most desirable to keep the dose at the lowest level compatible with adequate pain relief. Therefore, administration should be started with two capsules per dose, increasing to three only if the analgesic effect is insufficient.

Tolerance to any narcotic drug develops more rapidly with excessive dosage and under regular by-the-clock administration. Also, as a rule, the pain of cancer varies widely in intensity from time to time. Pain, therefore, should be the only guide to time of administration and dosage level. Tolerance to Metopon hydrochloride develops slowly. It can be delayed or interrupted entirely by withholding the drug occasionally for twelve hours or for as much of that period as the incidence of pain will permit.

To each physician will be sent a record card for

*From the National Research Council, Washington, D. C.*

each patient to whom Metopon hydrochloride is to be administered. He will be requested to fill out these cards and return them in the addressed return envelope. He must furnish this record of the patient and his use of Metopon hydrochloride if he wishes to repeat his order for the drug. The principal object of this detailed report is to check the satisfactoriness of Metopon hydrochloride administration in general practice. The physician's cooperation in making it as complete as possible is earnestly solicited.

\* \* \* \*

The limited use of Metopon hydrochloride as described above has been recommended by the Drug Addiction Committee of the National Research Council, and the Committee with the cooperation of the American Cancer Society will supervise the distribution of the drug. The committee is composed of William Charles White, chairman, Washington, D. C.; H. J. Anslinger, commissioner of narcotics, United States Treasury Department, Washington, D. C.; Lyndon F. Small, National Institute of Health, Washington, D. C.; and Nathan B. Eddy, National Institute of Health, Washington, D. C. Queries and comments on Metopon may be directed to Dr. Eddy, who will answer them for the committee.

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7. Lee, L. E. Studies of morphine, codeine and their derivatives. XVI. Clinical studies of morphine, methyl dihydro-morphinone (Metopon) and dihydrodesoxymorphine-D (Desomorphine). *J. Pharmacol. & Exper. Therap.*, 75, 161, 1942.

## Construction Underway on New Psycho-surgery Building at Institute of Living

With the arrival of steel needed for the job, construction of the new \$200,000 psycho-surgery building at the Institute of Living in Hartford got under way September 15. Excavation for the six-story structure, which will be unique in the field, was completed some time ago.

Being built as an addition to the Burlingame Research Laboratories Building the new structure will have direct communication to the x-ray and other laboratory and research facilities in the Research Building. The new unit will contain special neuro-surgical operating rooms and twenty-six neuro-surgical beds. One entire floor will be devoted to class rooms and re-educational facilities to provide a special re-educational program for those who have undergone lobotomies or other forms of psycho-surgery.

## Admitted to College of Surgeons

The following ten Connecticut surgeons were among the 762 admitted to membership in the American College of Surgeons during its session in New York City in September:

Richard R. Barber, Glenbrook  
 William H. Curley, Jr., Bridgeport  
 John Paul Gens, Glenbrook  
 Milton L. Jennes, Waterbury  
 Harry C. Knight, Middletown  
 Charles W. Nichols, Bridgeport  
 John S. Papa, Bristol  
 William H. Ryder, New Haven  
 Louis G. Simon, South Norwalk  
 Felix F. Tomaino, Danbury

## Dr. Nichols 1947 Champion

Ralph W. Nichols of New Haven again has distinguished himself in golf by becoming the 1947 champion of the Connecticut State Seniors Golf Association. The Association recently celebrated its twenty-fifth anniversary by a tournament at the Norwich Golf Club, followed by a dinner at which the members were guests of the Norwich group. James Douglas Gold of Bridgeport as retiring president did the honors of the occasion in his usual masterly fashion.



Announcing--

## “DOCTOR’S ORDERS”

A quarter-hour radio series to be presented Sundays at 1:15 P. M. over the Yankee Network, starting on October 26.

Each program will comprise dramatization of a health problem by an experienced radio cast, followed by an interview with a member of the medical profession.

Connecticut physicians will be requested to participate in these programs. Complete scripts will be mailed to participants in advance, with privilege of editing prior to broadcast.

“Doctor’s Orders” will provide a valuable medium by which practicing physicians may talk directly with the people concerning problems of health.

Sponsored by the Connecticut State Medical Society.

## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*

EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven

JOSEPH N. D'ESOP, New Haven

#### Research in Isotopes

Veterans Administration has announced the beginning of a limited research program into the use of radioactive isotopes for diagnosing and treating certain types of diseases afflicting veterans.

Dr. George M. Lyon of Huntington, W. Va., as chief of VA's Radioisotope Section, will be in charge of the program.

Dr. Lyon has had wide experience in the problems of health protection in connection with radioactive materials. He was one of the safety officers when the first atomic bomb was discharged in New Mexico and was in charge of all safety measures during the experimental tests at Bikini. Because of the safety measures employed in these tests, no individuals were injured as a result of the atomic explosions.

To advise VA in matters of policy and planning in the research program, a Central Advisory Committee on Radioisotopes has been appointed.

This committee includes some of the nation's foremost authorities in medical research. Three of the members are particularly expert in the medical problems of nuclear fission. Members are:

Dr. Hugh Morgan, professor of medicine at Vanderbilt University, who was chief medical consultant to the U. S. Army during World War II.

Dr. Perrin Long, professor of preventive medicine at Johns Hopkins University, who was medical consultant to the Mediterranean Theater during World War II.

Dr. Stafford Warren, professor of biophysics and dean of the School of Medicine, at the University of California at Los Angeles and formerly medical director of the Manhattan District and chief of the radiological safety section at Bikini.

Dr. Hymer Friedell, professor of radiology of the School of Medicine, Western Reserve University and formerly assistant medical director of the Manhattan District.

Dr. Shields Warren, professor of pathology at

the Harvard Medical School and formerly in charge of Navy Medical Mission, Japan, and more recently executive officer of the Naval medical research section at the Bikini Tests.

Dr. Shields Warren will serve as special area consultant for the program in eastern United States; Dr. Friedell will be area consultant for the central states, and Dr. Stafford Warren will serve in a similar capacity for the western states.

The radioisotope program, during the next year, will be carried on at six VA hospitals. They are Framingham (Cushing), Mass.; Bronx, N. Y.; Cleveland (Crile), Ohio; Chicago (Hines), Ill.; Minneapolis, Minn., and Los Angeles (Birmingham), Calif.

At each hospital, the program will be under the general supervision of a Committee on Radioisotopes, which will be composed of prominent scientists from nearby universities participating in the VA medical program. These committees will be subcommittees of the local Deans Committees.

The radioisotope program will bear the same relationship to the universities, and its administration will be similar to that for the medical care and for the residency training program for physicians within VA hospitals.

#### Research in Heart Disease

Intensive research into heart disease which claims the lives of more veterans than any other disease will be centered at the Veterans Administration Mount Alto Hospital in Washington, D. C.

The new research center, a part of which already is in operation, was developed under the supervision of Dr. George P. Robb, widely known cardiologist and assistant medical director of the Metropolitan Life Insurance Company. He will continue as consultant to the cardiovascular research unit.

In addition to being the most frequent cause of death among veterans, heart disease is one of the most frequent causes of morbidity requiring extensive hospitalization of veterans.



The research center will conduct scientific investigations of cardiovascular physiology and pathology employing modern methods of study such as angiocardiology, cardiac catheterization and electrocardiography with the direct purpose of improving the diagnosis and treatment of veterans.

It also will serve as a training center for VA doctors by providing postgraduate study and resident training for certification by the American Board of Internal Medicine.

It further will provide consultation service in cardiovascular disease through treating difficult and selected cases and those cases requiring special diagnostic procedures not elsewhere available.

### Rehabilitation of Deaf Veterans

Approximately 30,000 veterans of World War II who suffered hearing impairments in service are eligible for a special program of medical rehabilitation that Veterans Administration has established to help them overcome their handicap.

Eligible veterans may take advantage of this program whether they require medical attention to improve their hearing or whether they need rehabilitation to overcome the handicap of a permanent hearing impairment.

The complete rehabilitation course includes a series of hearing and speech tests, the selection and fitting of a hearing aid if indicated, auditory training, lip reading instruction and speech correction if necessary.

### Connecticut Veterans Administration Medical Society

This is the second year of the Connecticut Veterans Administration Medical Society, and it is believed to be the first medical society to be formed in any of the Veterans Administration installations in the United States. Its purpose is to coordinate various activities of the Medical Staff with Adjudication and Rating Boards, and to bring to the Staff new knowledge in modern methods of treatment to be used for the better care of the veteran.

During the month of October meetings were addressed by four resident VA physicians and also by James Hennessey of St. Francis Hospital, Hartford.

### Trudeau Award to Dr. Emerson

Kendall Emerson, M.D., managing director of the National Tuberculosis Association since 1928, has been awarded the 1947 Trudeau Medal in recognition of his outstanding service in the campaign against tuberculosis both in this country and abroad. Presentation was made at the formal opening of the forty-third annual meeting of the NTA at the Fairmont Hotel, San Francisco, California, on June 17. Max Pinner, M.D., editor of *The American Review of Tuberculosis*, who received the medal last year presented the award and read the citation accompanying it. Named in honor of Dr. Edward Livingston Trudeau, one of the founders and first president of the NTA, the medal is given annually by the Association for significant accomplishments in the tuberculosis control movement.

### New Medical Director of American Heart Association

The appointment of Dr. Charles A. R. Connor as medical director of the American Heart Association has been announced by Dr. Arlie R. Barnes, president of the Association.

Dr. Connor succeeds Dr. David D. Rutstein who recently resigned as medical director to take the post of professor of preventive medicine at the Harvard Medical School.

### Dr. Miller Receives Another Appointment

James R. Miller, president of this Society, has been appointed as a member of the AMA Board of Trustees to succeed the late Charles W. Roberts of Atlanta on the Committee of Rural Medical Service.

Word has been received of the resignation of George Blumer, M.D., now of San Marino, California, from the Advisory Committee on Scientific Exhibit.

### New Hospital for Alcoholics

Preparation of preliminary plans for the construction of a \$425,000 hospital for alcoholics in New Haven has been approved by the Real Assets Advisory Committee of the State Controller's Office.

The hospital will be used as a treatment center by the State Commission on Alcoholism. Its construction was authorized by the 1947 General Assembly.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

*President*, MRS. ROBERT J. COOK, New Haven

*President-Elect*, MRS. HAROLD W. WELLINGTON, New London

*First Vice-President*, MRS. CHARLES W. GOFF, West Hartford

*Second Vice-President*, MRS. JAMES DOUGLAS GOLD, Bridgeport

*Recording Secretary*, MRS. F. ERWIN TRACY, Middletown

*Corresponding Secretary*, MRS. EDWIN R. CONNORS, Bridgeport

*Treasurer*, MRS. FRANK DiSTASIO, New Haven

A most interesting and constructive meeting was held at Wampanoag Country Club, West Hartford, September 24, by the members of the Board of Directors and County and State Committee chairmen of the Woman's Auxiliary to the Connecticut State Medical Society. Forty-one were present.

At 10:30 A. M. each State committee chairman met with the chairmen of the counties and discussed problems and ideas. It was a splendid opportunity for an exchange of views.

Following the meetings, luncheon was served and the Board wish to thank Mrs. Norman J. Barker and Mrs. Kenneth F. Brandon for making all arrangements.

Mrs. Marjorie Shearon, PH.D., the speaker of the afternoon, amazed the group with information that is extremely beneficial to each and every one at this time.

Mrs. Cook called a meeting of the Board in the afternoon at which time reports were heard and accepted. Mrs. Harry Pennington, New Haven County, was appointed to represent the organization at the meeting of the Connecticut Cancer Society, Inc., in Meriden.

The fall meeting of the Woman's Auxiliary to the Connecticut State Medical Society will be held in New Haven on December 4, 1947 (time and place to be announced). Following the meeting the Auxiliary will be hostess at dinner to the House of Delegates and other members of the Connecticut State Medical Society. The dinner will be at the New Haven Lawn Club at seven o'clock. Our guest speaker will be Louis Hopewell Bauer, M.D., of Hempstead, L. I., president of the Medical Society of the State of New York, trustee of the American Medical Association, and one of the representatives of the American Medical Association at the first meeting of the World Medical Association in Paris. Dr. Bauer is also a member of the General Council of the World Medical Association. The subject of

Dr. Bauer's address will be "The World Medical Organization."

#### LITCHFIELD COUNTY

A Board meeting of the Woman's Auxiliary to the Litchfield County Medical Association was held at the home of Mrs. F. D. Ursone, Greenwoods Road, West Norfolk. Mrs. Winfield Wight of Thomaston presided.

Present at the meeting were the following officers and chairmen: Mrs. Wight, president; Mrs. Royal Meyers, Watertown, president-elect; Mrs. F. L. Polito, Torrington, vice-president; Mrs. F. D. Ursone, secretary; Mrs. D. W. Herman, Winsted, treasurer; Mrs. Francis Gallo, Winsted, public relations; Mrs. Thomas Danaher, Torrington, program; Mrs. John R. Elliott, Canaan, hospitality; Mrs. H. W. Markwald, New Hartford, *Hygeia*; Mrs. I. S. Goldberg, Torrington, publicity.

#### HARTFORD COUNTY

The Board of Directors held their first fall meeting, at which time plans for the year were made. The Board also voted to have a directory printed and mailed to each member of the Auxiliary. The semi-annual meeting will be held at the Hartford Golf Club. Dr. Edith J. Alpenfels, noted anthropologist, will be guest speaker. It is at this meeting that past president pins will be presented to Mrs. A. B. Landry and Mrs. P. S. Phelps. This pin was designed by one of the members, Mrs. Nicholas A. Marinaro. Hereafter each retiring president will receive a pin at the annual meeting in April. A concert is planned for Sunday, November 9, at the Town and County Club in Hartford. The participating artists will be members of the Auxiliary and husbands of members. To help increase the welfare fund a rummage sale will be held at the Masonic Temple in West Hartford on Tuesday, February 24, 1948. A newsletter including the plans of the year and reports of the various committees has been sent to the entire membership.



FAIRFIELD COUNTY

An early fall luncheon meeting of the Executive Board of the Woman's Auxiliary to the Fairfield County Medical Association was held at the home of Mrs. J. Grady Booe, Long Hill Road, Shelton. Reports of the officers were read. Plans for the fall County meeting were completed. Several ideas were discussed for the continuation of the project at Laurel Heights Sanatorium.

NEW LONDON COUNTY

The members of the New London Medical Society entertained the members of the Woman's Auxiliary at dinner at Riversea Inn, Fenwick Point, on Thursday, September 4. For those who could attend in the afternoon there were games and sports and for the ladies the bridge tables proved most alluring. Cocktails were served on the terrace, followed by a delicious dinner. This is the third party the doctors and their wives have had since the Auxiliary was organized. It seems to be the most popular way to promote acquaintanceship among the physicians' families and to stimulate a feeling of local cooperation.

The address by Marjorie Shearon, PH.D., delivered before the Woman's Auxiliary will be printed in full in an early issue.

Death of President-Elect

As our publicity goes to press we have received the shocking news of the death of Mrs. Harold W. Wellington of New London, our president-elect, on October 12. Mrs. Wellington was one of our most beloved members and her interest in our organization was an inspiration to all. The deepest sympathy is extended to Dr. Wellington and family,

LETTERS TO THE EDITOR

Newfoundland Medicine

To the Editor:

I have just returned from a six weeks' stay at the International Grenfell Association Hospital in St. Anthony, Newfoundland, where I went to do eye surgery. The following impressions of Newfound-

land Medicine have been set down because I thought your readers might be interested.

One of the glaring differences between the practice of medicine in Newfoundland and the United States is the complete absence of competition. There just are not enough doctors to go around. Another factor is that the economical situation of the people does not enable them to support doctors sufficiently to attract many men. The old idea that the level of medical service is only as high as that which the people demand and support seems to be a bit in reverse here. However, in spite of the economic difficulties the men, by and large, are medically equal to our average in Connecticut. In many places they are superior to men in similar background for it often becomes necessary, due to isolation and lack of medical help, for them to do procedures which are somewhat over their heads. Because of this circumstance they develop skill and surgical ability which is amazing. Many of these men are conscientious and perhaps idealists, as they would never have gone into some of these communities to practice had they considered either the monetary gain or the social advantages. Medicine to them is more than a means of making a living, it is a service to the people and a trust given to carry on to the best of one's ability.

The medical situation at St. John's is well covered by good hospitals, enough men to staff them, and standards approved by the American College of Surgeons. The situations outside of St. John's are the ones of interest. For example, Belle Island, near St. John, a mining community on an island with 8,000 people, 2,000 employed in the iron mines, has two doctors. They have their office and surgery together and one is retained at a low figure by the Mining Company to take care of its injuries. The other is not. They make their real living from the people. Office calls are fifty cents, when they get it, and a delivery is ten dollars, but they rarely get paid for over half of them. This knocks the fee down considerably considering they are home deliveries and they furnish a lot of their own supplies. Neither takes a vacation but rarely because he realizes, if he does, the other fellow gets no sleep at all covering 8,000 people. This place is well off as it is independent. Practically all other spots have to be government supported.

The government is attempting to provide more medical service to the people by setting up what

are known as cottage hospitals in strategic areas. The idea is to set up a doctor with a small staff of two or three nurses, with an office and hospital, and a minimum guarantee, so that with fair collection he may make two or three thousand dollars a year doing everything. What nursing help is obtainable may be a little rugged depending on training and intestinal fortitude for they do more work than our American nurses are allowed to. English nurses are preferred because of their midwife training. Medical students from American and British schools come up and help out during the summer. Some of the cottage hospitals have no doctors but the nurses do quite well. One practitioner has trained the janitor to be his first assistant at operations, as his wife, who is a nurse, is often too busy to help in surgery. If the patient is well off the doctors may get as much as ten or twelve dollars for an appendectomy and again, perhaps not. The hospital bill, which is anywhere from a dollar a day to two dollars and a half a day, will usually amount to more than the surgical fee. One thing they do not have are a lot of overfed hypertensive patients. The way of living here does not create this type of individual very often. Most of the patients are really sick and wait until quite late before asking for medical help. One community of about 5,000 has one man holding the fort. He is in his early sixties, has had several severe gastric hemorrhages, and has already had one gastric resection. He should quit or slow down, but the people are there and need help and he is going until he drops.

As loyal Connecticut doctors we have one man in Newfoundland from our state that we should be proud of. He came up here as a medical student during the summers and then returned to the Twillingate Hospital after a year's internship and later took over. Without much formal training, but with a lot of good books and a desire to help people and the courage to do the best he could under the conditions at hand, he has done a job that is utterly amazing. The man, in my estimation, has done as good a job as has Grenfell, but he lacks the flair for publicity that Sir Wilfred had. Dr. John Olds, of whom I speak and whom I think our Society should honor in some manner or other, is managing director, administrator, surgeon, doing the medical and surgical care of a 130-bed hospital at Twillingate, which covers an area of 30,000 people in Notre Dame Bay. On the fee basis such a hospital could not exist even though Dr. Olds only gets his living and a couple of thousand a year or less. The Government has to come to the rescue with grants to

keep the place going and the rest of the deficit is made up by support by a Board of Directors of various interested men in Newfoundland. The only vacation Dr. Olds has had in the past five years was last winter when he went seal hunting for a few weeks but got so sick that he had to be brought back for a rest.

The International Grenfell Association, of course, plays a tremendous part in the economic, social and medical life of the northern portion of Newfoundland. The well organized hospital, orphanage, sustaining farm, cooperative enterprises, and series of nursing stations are a fitting memorial to the genius who was able to set them up. Since 1931 Dr. Charles Curtis has done, as director, a job that is in my opinion equally as great in enlarging and keeping the setup functioning under, at times, terrific handicaps.

It is not the purpose of this letter to elaborate on details but merely to tell some things the other fellow is doing. There are certainly opportunities for young men to gain wide experience either during or immediately after medical school there. Also if you are a little tired of the "battle of neurosis" here at home you might go up to the Grenfell Mission for a summer. You won't regret it.

Paul W. Tisher, M.D.,  
New Britain, Connecticut

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### Dr. Paul Hawley Honored

Dr. Paul R. Hawley, chief of Veterans Administration Department of Medicine and Surgery, has been awarded an honorary fellowship in the American Association for the Surgery of Trauma. The association was organized in 1938, with the cultivation and improvement in the art of surgery and allied sciences as its main objectives.

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### Philadelphia Considers United Campaign for Hospital Fund Raising

A Citizens' Conference on Hospital Capital Needs of Philadelphia and vicinity met recently in that city and elected fifty-seven Philadelphians—physicians, hospital administrators and laymen—as a Board of Directors to explore and determine whether funds for improvement and expansion of local hospitals should be met by a unified money-raising drive or by independent campaigns. The sentiment of the meeting seemed to be strongly in favor of a joint fund campaign.



## THE DOCTOR'S OFFICE

Robert H. Abrahamson, M.D., announces the opening of an office for the practice of general surgery at 588 State Street, Bridgeport.

John T. Beebe, M.D., announces the opening of an office for the practice of internal medicine at 665 Asylum Avenue, Hartford.

Louis F. Castaldo, M.D., announces the opening of an office for the practice of otolaryngology, including broncho-esophagoscopy, at 10 Washington Avenue, Bridgeport.

Archibald S. Deming, M.D., announces the opening of an office for the practice of internal medicine at 715 Asylum Avenue, Hartford.

Milton W. Fabricant, M.D., announces the opening of an office for the general practice of medicine and surgery at 275 Montauk Avenue, New London.

John E. Franco, M.D., announces the opening of an office for the practice of internal medicine at the Westwood Building, 955 Asylum Avenue, Hartford.

Arthur J. Geiger, M.D., announces the opening of his office at 240 Bradley Street, New Haven. Practice limited to consultation in cardiovascular disease.

Harold T. Klein, M.D., announces the opening of an office for the practice of medicine and surgery at 578 Summer Street, Stamford.

Leo LaPalme, M.D., announces the opening of an office for the practice of general medicine in Putnam. He is now located in the office of his cousin, the late J. A. "Tony" LaPalme.

J. David McGaughey, M.D., announces that he is now associated with his father, James D. McGaughey, M.D., in the general practice of medicine at 261 Center Street, Meriden.

Seymour M. Miller, M.D., announces the removal of his office to 1711 Park Street, Hartford.

John Narowski, M.D., announces the opening of an office for the practice of medicine and surgery at 17 Elizabeth Street, Derby.

Anthony V. Nevulis, M.D., announces his return to practice at 49 Lexington Street, New Britain. Practice limited to orthopedic surgery.

Richard M. Newman, M.D., announces the re-

moval of his office to 158 Whitney Avenue, New Haven.

George H. O'Brasky, M.D., announces the opening of his office at 1142 Chapel Street, New Haven. Practice limited to diagnostic roentgenology.

Denis S. O'Connor, M.D., and Walter A. L. Thompson, M.D., announce the removal of their office for the practice of orthopedic surgery to 241 Edwards Street, New Haven.

Louis Olore, M.D., announces the opening of an office for the general practice of medicine at 195 Grove Street, Waterbury.

Maxwell Pasternak, M.D., announces the removal of his office to 129 Whitney Avenue, New Haven.

Daniel P. Richman, M.D., announces the opening of an office for the general practice of medicine at 30 West Avenue, Norwalk.

Daniel P. Samson, M.D., announces the opening of an office for the practice of medicine on Elm Street, Thomaston. Dr. Samson has purchased the home and practice of Henry G. Atha who has moved to Arizona because of ill health.

William B. Scoville, M.D., announces the removal of his office to 56 Garden Street, Hartford.

Edward V. Stevenson, Jr., M.D., announces the opening of an office for the practice of medicine in Thompson.

Victor L. Szanton, M.D., announces the opening of an office for the practice of pediatrics at 17 Elizabeth Street, Derby.

Edward T. Wakeman, M.D., announces the removal of his office to 240 Bradley Street, New Haven.

Robert A. Weston, Jr., M.D., announces the opening of an office for the practice of medicine at 114 Broad Street, Milford.

Benjamin Whitcomb, M.D., announces the removal of his office to 56 Garden Street, Hartford.

John T. Winters, M.D., announces the removal of his office to 10 North Main Street, West Hartford.

### Erratum

In the article from the State Department of Health entitled "The Poliomyelitis Season Approaches," published in the September 1947 issue of THE JOURNAL, page 784, the Waterbury Hospital should have been listed as having both hospital and state technicians in its physical therapy facilities.

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## OBITUARIES

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### J. Bayard Clark, M.D.

1869 - 1947

J. Bayard Clark was born in Elizabeth, New Jersey. He was a graduate of the Columbia University College of Physicians and Surgeons. He resided in Greenwich for many years, practising both in Greenwich and New York, and served on the staff of the Greenwich Hospital. A pioneer in his specialty of urology, he was certified by the American Board of Urology and formerly held the professorship of urology at the New York Polyclinic Medical School and Hospital. Dr. Clark also served in World War I.

Dr. Clark throughout his professional life was alert to all advances in modern medicine. His long experience and keen mind brought him the respect and esteem of those who were associated with him.

William B. Swarts, M.D.

### D. C. Y. Moore, M.D.

1869 - 1947

Demarquis De Casso Ye Rujo Moore, one of the last remaining of that glorious band of fast disappearing family physicians in the true and traditional sense, "D. C. Y.," as he was affectionately known to all of us, has closed his eyes in the long sleep. His fifty years of active medical practice in one community stand alone as the ultimate tribute to his character and worth, but medicine alone was not D. C. Y.'s only contribution to Manchester and to Connecticut. He felt keenly his obligations as a citizen and gave of himself unstintingly in the public good with the result that few, if any, local civic advancements failed to bear the mark of his able counsel and leadership.

His was a full life. Despite a large and demanding medical and surgical practice from the true horse and buggy days to the very last, D. C. Y. still found time to lead an extremely active civic and social life. The Manchester Memorial Hospital was one of his "babies;" chairman of Manchester's Health Board since 1913, he not only led the way locally but, through his foresight and consciousness of the vast scope of public health work and his encourage-

ment and cooperation with State officials, had much to do with the furtherment of the broader aspect of Connecticut's public health program; the Manchester Country Club and the local Kiwanis organization were midwived by D. C. Y. He was a charter member of the Manchester Chamber of Commerce and the Manchester Rod and Gun Club and, in his day, one of the outstanding rifle shots in the state; his collection of guns was widely known. A member of local, county, state, and national medical societies, he was widely known, highly respected by his colleagues, and honored many times by them in election to various offices. D. C. Y.'s membership was always an active and self-sacrificing one; a rugged, handsome man (always fastidious in appearance), he somewhere found the time and energy—and means, if indicated—always to make his contribution more than mere lip service.

Doctor, citizen and civic leader, sportsman, counselor and friend—we'll all miss him, but his influence will be with us.

Ralph M. Lechause, M.D.

### Henry Stempa, M.D.

1878 - 1947

On June 12, 1947 death brought to a close the career of Dr. Henry Stempa in his sixty-ninth year.

Dr. Stempa was born in Germany August 27, 1878. He received his doctorate in medicine in 1898 at the University of Berlin. Like many another subject of the Reich, his conscience did not permit his loyalty to the changing ideas developing in his native land. In consequence, when he was about forty-five years of age, he emigrated to the United States where he subsequently became a naturalized citizen and spent the remainder of his life with his wife and daughter, who survive him.

Between 1923 and 1925 his work was at the University of Wisconsin. It was while there that he received an injury to his leg that proved to be a crippling handicap to locomotion throughout his life. This undoubtedly had its influence on his subsequent practice of medicine. Having had intimate experiences with bed-rest, plaster casts and braces himself, his approach to others similarly afflicted was more personal and human.



He spent several years as a member of the medical staff at Boehne Tuberculosis Hospital, Evansville, Indiana. In 1929 he came to Connecticut and became a resident physician at Cedarcrest Sanatorium where he remained for eleven years. In 1940 he entered private practice in Wethersfield. Here he devoted himself to certain phases of orthopedic and chronic nutritive disorders, holding certain office hours also in New York City.

Dr. Stempa was of an investigative turn of mind. He gave much thought to obscure physical abnormalities. He aimed not alone to palliative measures but also to overcoming malnutrition where he believed it to contribute to tuberculosis of bones or chronic disease of joints.

Henry Stempa was a quiet and unassuming man. Although less well known among the medical profession, he enjoyed an extensive friendship and inspired confidence among the patients who consulted him from far and near. Of these a host remains to mourn his departure and miss his kindly ministrations.

Ralph deBallard Clarke, M.D.

### AMA Will Honor General Practitioner by Gold Medal

The Board of Trustees of the American Medical Association has established a special gold medal for a general practitioner who has rendered exceptional service to his community.

The award, similar to the American Medical Association's Distinguished Service Medal which has been given annually since 1938 for scientific advancement in the field of medicine, will be given to a general practitioner for the first time at the supplemental session of the House of Delegates at Cleveland, Ohio, on January 7, 1948.

Designed especially for the physician who has served his people as a family doctor and who does not devote himself exclusively to a specialty in medicine, the award will be known as "the medal of the American Medical Association for exceptional service by a general practitioner."

Nominations for the award may be submitted to the headquarters office of the American Medical Association in Chicago by any state medical association or community service club, such as a Rotary, Kiwanis or Lions Club, Chamber of Commerce.

woman's club, community council or similar group. The nomination should include the name and address of the physician, his scholastic record and a record of his medical service in the community.

Nominations will be submitted to the executive committee of the Section on General Practice of Medicine of the American Medical Association, which is composed of Dr. Wingate M. Johnson, Winston-Salem, N. C.; Dr. Paul A. Davis, Akron, Ohio; and Dr. E. A. Royston, Los Angeles. This committee will select five leading candidates for nomination for submission to the Board of Trustees, which, in turn, will nominate three of these to the House of Delegates. On the opening day's meeting at the supplemental session the House of Delegates will choose by ballot the general practitioner who will receive the medal.

### Medical Service Corps Created as Part of Regular Army

A far reaching change in the permanent organization of the Medical Department of the Army went into effect August 5 following President Truman's approval of legislation creating a Medical Service Corps in the regular establishment.

This legislation makes it possible for the first time to give Regular Army commissions to specialists in the scores of fields now closely allied to medicine—to bacteriologists, entomologists, psychologists, sanitary engineers, pharmacists, chemists, electronics experts and the like. These will be grouped together in a new corps under the Medical Department of the Army.

The need has been evident for a long time. Up to now the Medical Department has been made up of six corps—Medical, Dental, Veterinary, Pharmacy, Nurse, and Women's Medical Specialists. It has been possible to commission specialists in other fields only in the reserve from which they could be called to service in a national emergency.

Under the present legislation the Surgeon General is free to use his discretion, as the need arises. An expert in enzyme chemistry, for example, can be given a regular commission in the new Medical Service Corps with no more complications than would be involved in commissioning a brain surgeon in the Medical Corps.

The strength of the new corps will be prescribed by the Secretary of War. Grades will range from second lieutenant to colonel.

## SPECIAL NOTICES

### CONFERENCES ON INFERTILITY PROBLEMS AT THE YALE SCHOOL OF MEDICINE

A series of six weekly conferences on infertility problems will be held in the Farnam Auditorium at 4:00 P. M. beginning November 4. The following program will be presented:

November 4

Dr. Walter W. Williams, Springfield, Massachusetts  
"Female Germinal Disease and Ovulation Time"

November 11

Dr. Walter W. Williams  
"Male Germinal Disease"

November 18

Dr. Somers Sturgis, Boston, Massachusetts  
"The Physiology of Reproduction"

November 25

Dr. Isidor C. Rubin, New York City  
"Tubal Insufflation"

December 2

Dr. Walter W. Williams  
"The Clinical Case Record and Its Research Value"

December 9

Dr. Walter W. Williams  
"Prognosis and Treatment of Sterility"

These conferences are offered as a postdoctorate course to Connecticut physicians. Those wishing to attend are requested to register with the Department of Obstetrics and Gynecology, The School of Medicine, Yale University.

### ASSOCIATION OF CONNECTICUT TUMOR CLINICS

The fall meeting of the Association of Connecticut Tumor Clinics will be held on November 13, 1947, at 4:00 P. M. at the New Haven Hospital. The following program will be presented by members of the Yale University School of Medicine:

1. Hormones and Mouse Tumor Studies  
Dr. William A. Gardner
2. The Possible Role of Viruses in Tumor Etiology  
Dr. Edward W. Shrigley
3. The Tumor Detection Clinic at New Haven Hospital  
Dr. Samuel C. Harvey
4. The Production of Carcinomas in Transplanted Embryonic Tissues  
Dr. Harry S. N. Greene
5. Self Studies of Sputum and Bronchial Secretion in the Diagnosis of Cancer  
Drs. A. A. Liebow, G. E. Lindskog, and W. E. Bloomer

All physicians of the State are cordially invited to attend the meeting.

Robert Tennant, Secretary

### AMERICAN ACADEMY OF ALLERGY CONVENTION

The American Academy of Allergy will hold its annual convention at Hotel Jefferson, St. Louis, Missouri, December 15-17, inclusive. All physicians interested in allergic problems are cordially invited to attend the sessions as guests of the Academy by registering without payment of fee. The program, the scientific, and technical exhibits have been arranged to cover a wide variety of conditions where allergic factors may be important. Papers will be presented dealing with the latest methods of diagnosis and treatment as well as the results of investigation and research. Round table conferences will be held on Monday afternoon, December 15, 1947. Advance copies of the program may be obtained by writing to the Chairman on Arrangements, Charles H. Eyermann, M.D., 634 North Grand Boulevard, St. Louis, Missouri.

The American Urological Association offers an annual award of \$1000 (first prize of \$500, second prize \$300 and third prize \$200) for essays on the result of some clinical or laboratory research in urology. Competition shall be limited to urologists who have been in such specific practice for not more than five years and to residents in urology in recognized hospitals.

The first prize essay will appear on the program of the forthcoming meeting of the American Urological Association, to be held at the Hotel Statler, Boston, Massachusetts, May 17-20, 1948.

For full particulars write the Secretary, Dr. Thomas D. Moore, 899 Madison Avenue, Memphis, Tennessee. Essays must be in his hands before March 1, 1948.

### GENERAL INFORMATION CONCERNING U. S. PUBLIC HEALTH SERVICE RESEARCH FELLOWSHIPS

The Surgeon General of the U. S. Public Health Service has been given the authority to establish and maintain research fellowships. These fellowships are intended to promote the training and development of investigators in the field of medicine and related sciences.

#### TYPES OF FELLOWSHIPS AWARDED—STIPENDS

1. A predoctorate research fellowship\* at the Bachelor level is available to qualified applicants who have a Bachelor's Degree. This fellowship carries a stipend of \$1,200 for successful applicants without dependents and \$1,600 per

\*These predoctorate fellowships are also granted to medical students who, having completed one or two years of their medical course and contemplating a career in medical research, wish to spend one, two or three additional years in a basic science (biochemistry, physiology, physics, etc.) before completing their studies toward the M.D. degree.



annum for this fellowship awarded to persons with dependents. In addition, the tuition fee is paid by the U. S. Public Health Service.

2. A predoctorate research fellowship\* at the Master level is available to qualified applicants holding a Master's Degree or its equivalent in graduate training. This fellowship carries a stipend, in addition to tuition fees, of \$1,600 for persons without dependents and \$2,000 for persons with dependents.

3. A postdoctorate research fellowship is awarded to qualified persons holding a Doctor's Degree in medical or related fields. This fellowship does not provide tuition fees but carries a stipend of \$3,000 per year for Doctors without dependents and \$3,600 per year for those with dependents. An increase of \$300 each year is granted to those Doctorate Fellows who are reappointed.

4. Special research fellowships are awarded to applicants who qualify for a postdoctorate fellowship and in addition have demonstrated outstanding ability or who possess specialized training for a specific problem. This fellowship does not carry a set stipend but is determined in the individual case.

TERM OF FELLOWSHIPS

Fellowships are awarded for one-year periods and may be renewed. Except in unusual circumstances, Postdoctorate Fellows are not reappointed for third year.

TIME OF AWARD OF FELLOWSHIPS

Fellowship applications are acted upon and fellowship awards are made at approximately three month intervals.

VACATIONS

U. S. Public Health Service Research Fellows may take vacations in accordance with the rules of the institution with which they are working, but not to exceed one month during the tenure of the fellowship; vacations "earned" but not taken during the fellowship cannot be compensated for subsequent to the term of the fellowship appointment.

TRAVEL ALLOWANCES

Travel grants are not made to Fellows except that travel expenses (first class transportation) only may be granted from the institution of residence or from the home of the Fellow to the institution selected for fellowship training. No allowances will be made for return travel, travel of dependents, or for shipping charges for personal effects and/or household goods.

CONCURRENT FELLOWSHIPS

U. S. Public Health Service fellowships will not be awarded or continued concurrently with the awards of other fellowships except in most unusual circumstances.

PROGRESS REPORTS

Progress reports are required at the end of eight months from those Fellows who contemplate applying for reappointment and at the end of the fellowship year from all others. The person under whom the Fellow is working will be requested to submit a report on the Fellow.

INCOME TAX EXEMPTION

U. S. Public Health Service has been notified by the

Collector of Internal Revenue that "generally where fellowships or scholarships are awarded to individuals in order to enable them to pursue a particular line of research or study, for their improvement and benefit, and no consideration of any kind is given by the recipient in return for such an award, the amount received is considered a gift or gratuity and would not be subject to withholding tax."

TEACHING BY FELLOWS

Fellows are permitted to carry on not more than one hour of teaching or lecture or three hours of laboratory instruction per week during one semester only.

EFFECTIVE DATE FOR BEGINNING FELLOWSHIPS

Although fellowships are awarded approximately every three months, the effective date for beginning fellowship work can be set at any time to suit the convenience of the successful applicant and the institution in which he will be working.

APPLICATION FORMS

Forms of application for a research fellowship may be obtained from the Division of Research Grants and Fellowships, National Institute of Health, Bethesda 14, Maryland.

1. This application form, one copy only, is to be filled out and sent to the Division of Research Grants and Fellowships.

2. The application is to be supported by transcripts of scholastic records and when available by a statement as to relative standing in the class.

3. The application must be supported by letters of recommendation from persons named by the applicant in the application form.

4. The application must be supported by a statement from the department head or other responsible person under whom the fellowship work is to be conducted indicating that satisfactory arrangements have been made with him and with the institution. It is the responsibility of the applicant to make necessary arrangements for the conduct of the proposed research fellowship work and the work may be conducted at any acceptable institution, including governmental research laboratories, such as are provided at the National Institute of Health, National Cancer Institute, etc.

SUPPORT OF THE U. S. PUBLIC HEALTH SERVICE RESEARCH FELLOWSHIP PROGRAM

The support of this program is derived from funds appropriated by the Congress for this purpose to Institutes or Divisions of the U. S. Public Health Service; therefore, fellowships awarded will carry a designation depending upon the funds used to support the fellowship: e.g., National Cancer Institute Special Research Fellow, Division of Mental Hygiene Postdoctorate Research Fellow, National Institute of Health Predoctorate Fellow—Bachelor level, etc.

PUBLICATIONS

It is requested that all publications resulting from work carried on by U. S. Public Health Service Research Fellows carry in a footnote acknowledgment of the fellowship award, and that two reprints of each such report be furnished the Division of Research Grants and Fellowships.

Regardless of the field of endeavor in which the Fellow hopes to conduct his research investigation, all applications should be addressed to the Division of Research Grants and Fellowships, National Institute of Health, Bethesda 14, Maryland, where all applications will first be reviewed by a Central Qualifications Board, and subsequently by one of the Specialty Fellowship Boards of the Division or Institute concerned. Similarly, all questions in regard to the Fellowship Program, both by applicants and by Fellows, are to be directed to the Division of Research Grants and Fellowships, which will be pleased to assist in any way possible.

### 1947 EDITION OF PARERGON

Parergon (work by the side of work) is Mead Johnson & Company's picture book of artistic works by physicians.

The current edition is a book of 208 pages and shows 1,100 examples of creative art by contemporary physicians.

This book is available without charge only to physicians upon request of Mead Johnson & Company, Evansville 21, Ind., U. S. A.

### Aid to Medical Schools a Necessity

"We warn our fellow citizens that without their prompt and generous aid our medical schools, through their graduates, cannot be expected to safeguard the health of American citizens and their children."

This blunt warning was contained in a joint statement signed by the presidents of 19 universities operating leading medical schools, and made public March 15 at the twentieth commencement exercises of the Rochester School of Medicine and Dentistry, Rochester, N. Y.

Read by Dr. Alan Valentine, president of the University of Rochester, the statement was signed by the following university heads, according to an account in the *New York Herald Tribune*:

Robert G. Sproul, University of California; Frank Diehl Fackenthal, acting president, Columbia University; Edmund Ezra Day, Cornell; Robert L. Flowers, Duke; James B. Conant, Harvard; Virgil M. Hancher.

Although "recent years have brought certain notable advances in medical knowledge and care, including penicillin, sulfa drugs, and blood substitutes," signatories of the statement express their concern that "those advances may have given the public the impression that future progress in medical care and the maintenance of high qualitative stand-

ards in medical education are assured."

"Such is not the case," the statement continues. "New hospitals and clinics, new drugs, medical insurance plans and state subsidies to medicine do not in themselves assure proper medical care. They must be wisely used by an adequate number of skilled physicians. It is only through the hands and minds of men and women trained by our medical schools that society can be given sound medical care and new developments utilized."

"The present provisions for insuring a continuing supply of well trained physicians are inadequate. They are inadequate because the medical schools which provide that supply are inadequately supported in terms of future needs. Few, if any, of the 70 recognized medical schools in the United States can be confident, with present resources, of maintaining in the future their programs at the essential high level.

"Forty-three of these 70 schools are maintained solely by income from private endowment, private gifts, and tuition fees of students. Many of the endowed schools are of the first quality. They have set the pace for medical education. American society cannot neglect their future.

"Even the 27 schools wholly or partly supported by taxes depend upon private sources for important parts of their program.

"Good medical education is the most expensive form of professional training. It requires a large number of skilled teachers in proportion to the number of students. It needs expensive plant and equipment, with hospital facilities immediately available. It involves generous provision of teachers' time, and funds for research. As medical knowledge becomes more extensive, the costs of imparting that knowledge mount. Most of the costs cannot be paid by medical students, and tuition fees are already as high as most students can pay. Expenses of medical schools run as high as \$4,500 or more each student a year. The costs which make up this total have constantly mounted and will probably continue to mount. Meanwhile, income from invested funds seems likely to remain low.

"These costs of medical education must be met if it is to be maintained at the level necessary to insure proper medical care. In private institutions they can be met only by large increases in endowment funds, or long term gifts, or both."



## Dr. Parran Wins PHA Lasker Award

Dr. Thomas Parran, surgeon-general of the United States Public Health Service, was announced recently as one of seven winners of the annual Lasker awards of the American Public Health Association for 1947.

The winners were announced by Dr. George Baehr, president of the New York Academy of Medicine and chairman of the Awards Committee, at a news conference.

Dr. Alice Hamilton, seventy-eight, of Hadlyme, Conn., who Dr. Baehr said spent a lifetime in developing methods to prevent occupational diseases, was also awarded \$1,000, a gold statuette and a citation.

## New Medical Director in Public Welfare Department

Dr. William C. Horton of Wendel, North Carolina, has been appointed medical director of the State Public Welfare Department.

The appointment was recently announced by Welfare Commissioner Robert J. Smith. Dr. Horton will succeed Dr. Philip W. Fenney, who resigned last spring to accept a government position at Staten Island, N. Y. Born in Fall River, Mass., Dr. Horton received his medical degree at Boston University School of Medicine. During the war he served as a medical officer with the 99th General Hospital in the European Theater of Operations.

## Lobbying Costs

One hundred and thirty-two pressure groups representing one-fourth the total number of lobbyists registered with Congress spent nearly \$2,700,000 during the first six months of 1947. On the other hand the National Physicians Committee for Extension of Medical Service spent \$135,377 opposing medical insurance features of the Wagner-Murray-Dingell bill which never approached the passage stage during the last session.

## Oregon Society Has Woman as President

The Oregon State Medical Society has elected a woman as president for the first time in its seventy-three-year history. The woman physician, who will take office a year from now, is Leslie S. Kent, a graduate of the University of Wyoming, who has practiced medicine in Eugene, Oregon, since 1923.

# OUR NEIGHBORS

## Massachusetts

The Council of the Massachusetts Medical Society distributes through the various district secretaries to each applicant for membership a circular calling attention to the Code of Ethics of the Society and to the Principles of Medical Ethics of the American Medical Association which accompany the circular. Each district society is further requested to examine the applicant on the content of the circular and its censors are expected to determine the candidate's fitness for membership to a large extent by the answers that he gives. This procedure has been developed because of the fact that in the last few years a number of instances have arisen in which the offending Fellow of the Society apparently had no acquaintance with the Code of Ethics and was ignorant of ethical procedure with regard to his relations with his fellows.

The Council also voted to permit the establishment of women's auxiliaries within the district societies and ordered an auxiliary established within the State Society.

Dr. Henry Viets of Boston has been elected chairman of the Council of Scientific Assembly of the AMA.

Dr. Guy W. Brugler of Cleveland Heights, Ohio, has been named director of the Children's Hospital, Boston, and the proposed \$10,000,000 Children's Medical Center there, it was announced recently by J. W. Farley, president of the hospital's Board of Trustees.

He succeeds Dr. Stanton Garfield, who has been acting director of the institution, the nation's only general hospital for children.

Dr. Brugler has been assistant director of University Hospitals in Cleveland since 1939. He was on leave of absence during World War II and was with the American Army's 4th General Hospital in Australia and New Guinea for two years, with the rank of Lieutenant Colonel. Subsequently he was executive officer at the Army's Woodrow Wilson General Hospital in Staunton, Va., and served with the War Department Special Staff in Washington.

He was graduated from Ohio University in 1929 and from the School of Medicine, Western Reserve

University in 1933. He is a member of the Senior Medical Advisory Group to the Veterans Administration, and of the American College of Hospital Administrators.

### New York

Columbia University College of Physicians and Surgeons has arranged an affiliation with Mary Imogen Bassett Hospital at Cooperstown, N. Y., to provide training in rural medicine for students of the college. Columbia medical students will serve as clinical clerks at the hospital while staff physicians at the hospital who give instruction will be appointed to appropriate academic posts at Columbia.

E. D. Friedman, chairman of the Department of Neurology at New York University College of Medicine retired on September 1. He has assumed the title of professor emeritus. A teacher at the College for the past thirty-seven years, Dr. Friedman became a prominent figure in New York medical circles and a well known medical author. In the future he will devote his time to research in diseases of the nervous system, to some duties as a teacher of graduate neurology and to private practice in his field. He was born in New York City August 25, 1884 and was educated in the City's public schools and at the College of the City of New York. He graduated from New York University College of Medicine in 1907 and did post-graduate work at the University of Vienna in 1908-1909 and at the University of Berlin in 1913. During his continuous teaching career at the College since 1913, he became successively instructor in neuropathology in 1919, lecturer in neuro-pathology in 1922, clinical professor of neurology in 1924 and professor of neurology and head of the department in 1927.

Nevil Ford, vice-president of The First Boston Corporation, has accepted the general chairmanship of the \$15,575,000 New York University-Bellevue Medical Center campaign.

New York City is to spend \$135,686,700 for seventeen projects involving construction of new hospitals and reconversion of some existing ones. This capital program for the next two years approved by the Board of Estimate represents a cut from an original list of fifty-one items submitted by the hospital commissioner to Mayor O'Dwyer. The situation with respect to the care of chronic disease patients is said to be desperate. Additional

facilities for tuberculous patients are equally urgent. To give adequate care to these two categories alone 10,000 additional beds are needed.

### New Jersey

New Jersey now possesses a Physicians Post of the American Legion. This is the only veterans' organization in that State limited exclusively to physicians and one of the few such units in the United States. More than 200 physicians had joined the Post by July 1.

### Rhode Island

Two innovations were added to the Rhode Island campaign for student nurses which was concluded this spring. The first was a tea and program for counselors of all Rhode Island secondary schools which marked the opening of a two-week campaign to interest high school seniors and recent graduates in the opportunities for a career in nursing. The second was an invitation to every girl in the junior and senior classes of the high schools in Rhode Island to attend one of the five open house programs held at each of the schools of nursing. *The American Journal of Nursing* attributes the larger enrollment in the schools of nursing this year in Rhode Island to last year's campaign. This year's campaign was even more successful.

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## NEWS

### *from County Associations*

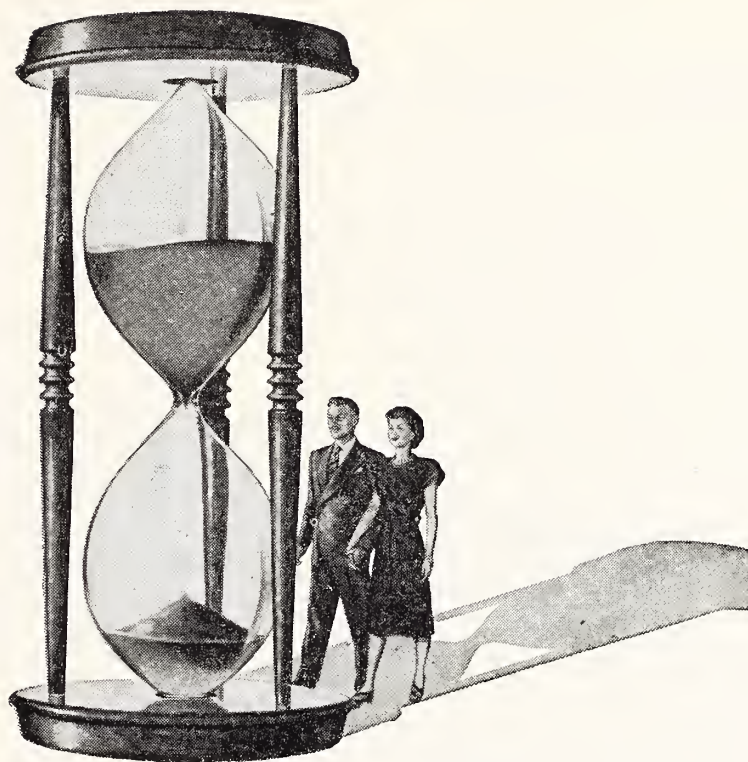
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#### Fairfield

The 156th semi-annual meeting of the Fairfield County Medical Association was held on October 1, 1947 at the Wee Burn Country Club, Darien. The beautiful fall weather attracted a large crowd. Golfers began to arrive well before noon and, in the course of the early afternoon, more than seventy had teed off. No official scores were kept but from the reports afterwards it was found that the poor golfers were especially good and the good golfers even better than usual. The veracity of many of the stories was not checked. Needless to say, however, the golfers enjoyed themselves.

The business meeting was held at 4:30 P. M. It was highlighted by short talks from our state officers,





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and especially by an excellent paper given by our vice-president, Dr. Clifford D. Moore, on "Senescence." Those of you who did not hear that paper should encourage Dr. Moore to put it in the *State Journal* so the entire State and country will have the pleasure of reading it.

Twenty-nine applicants were elected to membership.

A social hour followed the business meeting after which one hundred sixty-two members of the association sat down to an excellent Southern fried chicken dinner. This is the largest number the author has ever seen at any meeting of the Fairfield County Medical Association.

After dinner we were entertained royally by the well known Franklin P. Adams. Mr. Adams introduced his talk by confessing that he did know a great deal about medicine.

Sam Mullins has a guilty conscience for, ever since he won the Henry S. Miles cup awarded to the low net scorer among the medical men of Fairfield County, he has realized that future golfers would have nothing to fight over. It is for this reason that Sam presented a beautiful cup to us at our last semi-annual meeting.

The Samuel F. Mullins cup is to be awarded annually to the low net scorer of the Fairfield County Medical Association at its fall meeting. It is to be held by the winner for one year and passed on to the next winner. Should any one member win it three times he will have permanent possession of it.

Many thanks to Sam for his thoughtfulness and generosity. I am sure we will remember him and fight over the cup for many years to come.

The Fairfield County Medical Golf Association held its final outing at the Yale Golf Course on September 17. A majority of the members were present, engaging in a strenuous afternoon battling, not only the little ball but the tough terrain. A very delicious dinner followed at the Red Lobster on the Boston Post Road. A final meeting of the year was held and it was the unanimous vote of all that the year had been a very successful one. The association is looking forward to next year and is making plans to again play at some of the most exclusive clubs in this vicinity. Dr. Ed Trautman has taken over the office of secretary vacated by George Buckhout who is busy with other county affairs, and we expect Ed to do as good a job as George did this year.

The Bridgeport Medical Association was honored and privileged to have the well known gynecologist, Dr. Emil Novak, address its fall meeting at St. Vincent's hospital on the night of October 7. The program committee held a dinner for Dr. Novak at the Brooklawn Country Club before the meeting. One of the largest crowds of the year was present to hear Dr. Novak discuss the treatment of the menopause. A buffet was served following the meeting at which many of Dr. Novak's acquaintances in this area were renewed.

In his annual report Richard O'B. Shea, M.D., health officer of Bridgeport, called attention to the urgent need of a qualified and experienced supervisor of school health to be appointed to that division of the Bridgeport Health Department. He also stressed the need for the appointment of at least three additional dental hygienists and of a trained sanitary engineer. Dr. Shea was a delegate to the American Public Health Association convention in October.

## Hartford

David N. Shulman, M.D., has been appointed by Mayor Allen to a vacancy on the Hartford Housing Authority caused by the resignation of Edward W. Gilligan.

The Bristol Hospital has the distinction of claiming as its full time pathologist Dorothy W. Brockway, the second woman physician to be granted a license in the history of that town. Dr. Brockway was graduated from Vassar College in 1939 and Long Island College of Medicine in Brooklyn, N. Y. in 1943. She served as an intern at King's County Hospital in New York and from 1945 to 1947 was a licensed general practitioner in King's County.

George F. Cook, M.D., health officer of Plainville, has recommended a Public Health Council for that town to be composed of recognized leaders in seven or eight representative fields.

Dr. D. C. Y. Moore of Manchester in his will bequeathed his extensive medical library and instruments to Manchester Memorial Hospital.

About 300 persons witnessed the exercises attending the laying of the cornerstone of the new building at the Hartford Hospital on October 12. The actual laying of the cornerstone was done by Governor McConaughy. Among the speakers were Wilmer M. Allen, M.D., director, and Douglas J. Roberts, M.D., president of the staff.

Dewey Katz of Hartford attended the meeting of



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... published in behalf of the medical profession

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Following you through the years, he gains a unique understanding of you as a person.

He knows whether you have, normally, a fast pulse or a slow one; whether you run a high temperature on slight provocation, or only in serious illness.

He knows what strains your job places on you; what your past problems have been; what to look out for as a danger signal in the future.

This knowledge, which deepens every time he sees you, serves him well when you are ill. For he can judge the importance of your symptoms against the background of your individual history.

With this knowledge he can also help you avoid many kinds of illness. By detecting and taking care of minor ailments early, he can often keep them from becoming serious.

By his years of training and experience, and his continuing study of advances in medical science, your family doctor is qualified to deal with the many and varied medical problems that arise in his daily practice.

Give him your complete confidence at all times and follow his recommendations.

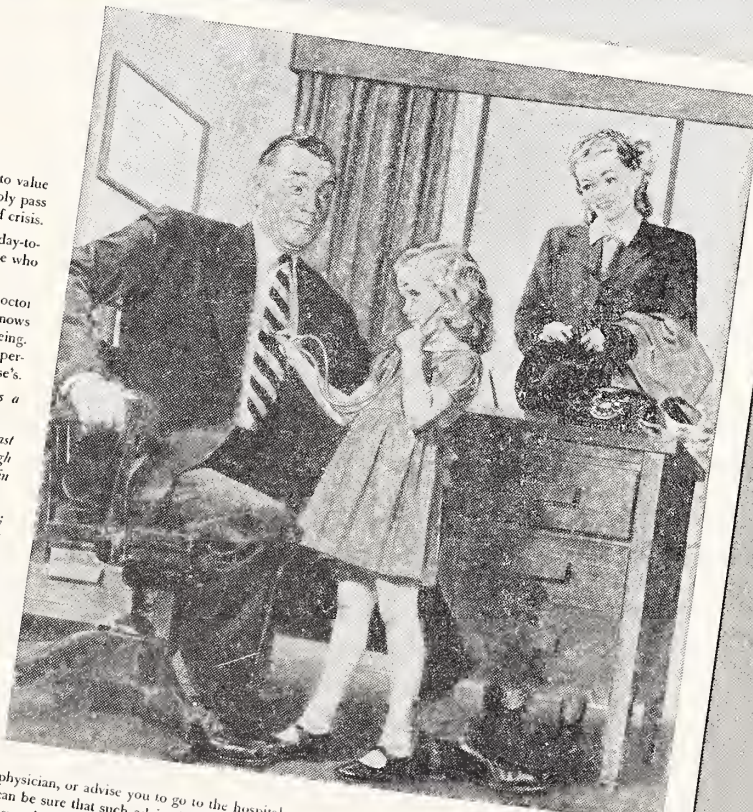
Should he suggest a consultation with a fellow

physician, or advise you to go to the hospital, you can be sure that such advice is based on his broad general knowledge of medicine plus his familiarity with your particular case.

**SEE YOUR DOCTOR.** Make him a part of your family's life. His continuing supervision is your best

guarantee that your children will grow up well and strong, and that you will live a long and healthy life.

And through the years, turn to him whenever you are troubled by a problem concerning your health. His wisdom and friendly understanding make him the best counselor anyone could hope to find.



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the American Academy of Ophthalmology and Otolaryngology as a member of its faculty. He presented a paper on "Field Defects." The meeting was held in Chicago in October.

### New Haven

The New Haven City Health Department in June 1946 initiated a program of mass x-ray using a 70 mm photoroentgen unit. Previously no x-raying equipment has been available in the city for mass surveys. Tuberculin testing in schools and irregular x-ray of positive reactors and select contacts by commercial x-ray firms comprised the tuberculosis casefinding program. The Bureau of Tuberculosis Control has as its objective the improvement of casefinding and routine x-ray of known contacts and other segments of the population which are productive sources of tuberculosis. Hence, with the installation of x-ray equipment, intensive drive was given to casefinding in special groups. Dr. Clement Batelli, director of the Bureau of Tuberculosis Control, developed a program of x-raying at the Health Department the first half of each month special groups: i.e. food-handlers, barbers, patients referred by private physicians and known tuberculosis contacts. These individuals report of their own volition or through referral of public health nurses, employers or physicians. The unit in the latter part of each month is available for industrial or neighborhood x-ray programs. The New Haven Tuberculosis and Health Association is aiding in the stimulation of private industry, through management, to offer x-ray facilities to its employees.

The New Haven Medical Society resumed its regular meetings in October. On November 5 Robert S. Hotchkiss of Cornell will speak on "Clinical Management of Infertile Men," and on November 19 Harvey B. Stone of Johns Hopkins will present "Large Obscure Bleeding from the Bowel."

Mr. Charles V. Wynne, former assistant superintendent of the New Haven Hospital, has recently assumed his duties as superintendent of the Waterbury Hospital.

Benjamin Tenney, Jr., of Boston spoke to the Waterbury Medical Society October 9 on the subject, "The Present Status of the Endocrines in Gyn. and Obs."

### New London

George Mahoney joined the staff of the Uncas-on-Thames on October 1 as an assistant physician.

He is a graduate of the University of Colorado, class of 1937. Welcome to our medical circle.

It is with great pleasure that we learn that Dr. William H. Weidman, superintendent of the Uncas-on-Thames, has resumed part of his duties following a protracted illness. His many friends will hail this announcement with real and sincere joy and with a prayer of thanks for his excellent recovery.

The new maternity building adjoining the old one at the W. W. Backus Hospital, Norwich, has been opened literally with open arms. It will fill a much needed place in our hospital community for the case load upon the old building caused real concern. It is a beautiful addition, structurally, and should be the means of better and safer care for maternity patients.

### Windham

The semi-annual meeting of the Windham County Medical Association was held in Putnam, at the Country Club, on Thursday, October 16. Seldon D. Bacon, PH.D., of Yale University, and chairman of the Connecticut State Commission on Alcoholism, discussed the "Alcohol Problem" in Connecticut.

Playing in bad luck, E. J. Ottenheimer of Willimantic has again had to retire from practice because of his health.

Dr. Bruce Roberts Valentine, M.D., of Abington, with the Eliza F. Clark Memorial Center Foundation, plans to open an office for general practice in Abington.

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## News from Yale University School of Medicine

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### Reorganization of Psychiatric Department

Complete reorganization of the Department of Psychiatry at Yale University, with emphasis on the newest methods of treating mental illness, expanded instruction of medical students and residency training in cooperation with the Veterans Administration has been announced by Dr. C. N. Hugh Long, dean of the Yale School of Medicine.

The psychiatry changes at Yale involve several personnel changes. Dr. Frederick C. Redlich has



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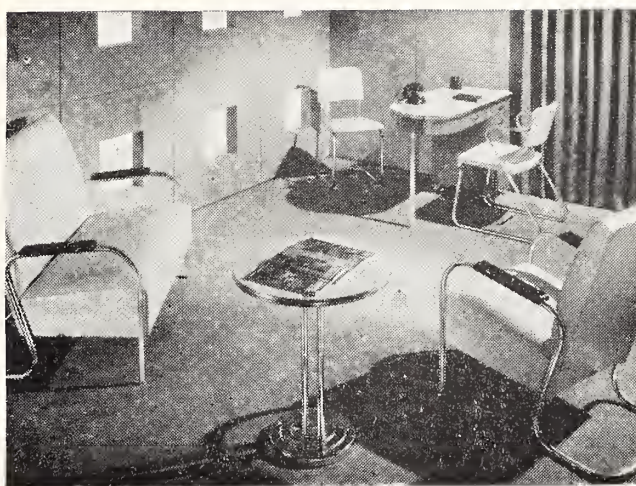
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been appointed executive officer of the Department. Dr. Burness E. Moore is physician-in-charge of the Psychiatric Inpatient Clinic and Dr. Richard Newman is physician-in-charge of the Outpatient Clinic.

Dean Long reports that several other new appointments will strengthen the teaching program of the department and "will help to orient treatment along dynamic lines." These include: Dr. Lawrence Kubie, clinical professor of Psychiatry; Dr. Robert P. Knight, medical director of the Austin Riggs Foundation of Stockbridge, Mass., also as a clinical professor; and Dr. Paul Yakovlev, director of research and training at the Connecticut State Hospital, as associate clinical professor.

Special attention is being given to the problem of making the teaching program and clinical services more responsive to the needs of New Haven and the state.

The Psychiatric Inpatient Clinic, which is located in the Yale Institute of Human Relations Building, is now in the process of being completely renovated. The first floor of the clinic is now an open wing, without the locked doors which contribute to the anxiety of patients who do not need such restraint.

Increasing emphasis will be placed in the Clinic on the psychoneuroses and on psychosomatic disorders. These patients will be accommodated on the open wing, and will be cared for jointly by the psychiatric staff and internists of the staff of the Yale School of Medicine and the New Haven Hospital. Members of the clinical staff of the Department of Psychiatry, who live in this immediate vicinity, will have the privilege of exercising direct control in the care of their private patients whom they refer to this clinic for hospitalization.

An individualized treatment program has been set up with major emphasis upon psychotherapy in which resident physicians will be carefully supervised and directed. All of the common treatment procedures will be used when indicated, including electric convulsive therapy, insulin coma, prefrontal lobotomy and the conditioned reflex treatment of alcoholism. Two occupational therapists will be added to the staff.

The nursing service has been reorganized under Miss Margaret Hulburt, assistant professor of psychiatric nursing in the Yale School of Nursing.

An interesting aspect of the new program is the fact that Yale Divinity School students will serve as male attendants in the wards as a part of their teaching program.

Increasing emphasis will be placed on instruction of medical students in psychiatry. A new approach at Yale is the plan to help students deal more adequately with types of psychiatric problems encountered in general practice or in the practice of specialties other than psychiatry. This will be accomplished through instruction of students in psychiatry in the medical Outpatient Dispensary as well as in the Psychiatric Clinics. While still functioning as a diagnostic clinic primarily, the Psychiatric Outpatient Clinic will accent the effective intensive treatment of the neuroses and the training of physicians and students in psychotherapy. The new supervisor of psychiatric social work will be Miss Nea Morton.

A new residency training program in neuropsychiatry, which will be under the Dean's Committee of the Veterans Administration, was started at Yale on October 1. Dr. Theodore Sohler has been appointed as chief of neuropsychiatry at the Newington Veterans Hospital in connection with this program. A Veterans Administration Contract Clinic is presently operating in the Psychiatric Outpatient Clinic.

A Connecticut Post-Graduate Seminar in Neuropsychiatry has been organized by Dr. Paul Yakovlev along the lines of the seminar in neuropsychiatry which he conducted at the Metropolitan State Hospital in Massachusetts for many years. This seminar will be sponsored by the Joint State Hospital Committee and Yale.

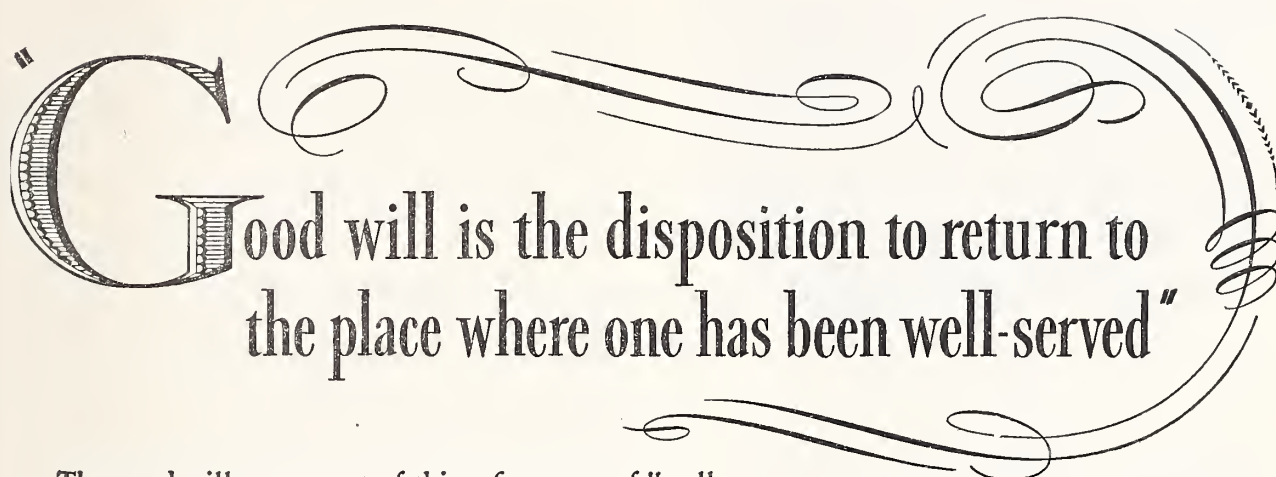
The Psychiatry Department will cooperate closely with the Yale Divinity School, Law School, Institute of Human Relations, the Department of Psychology, Department of Public Health and the Division of Psychiatry of the Yale Department of University Health under Dr. Clements C. Fry.

### Study of Infectious Hepatitis

Horace T. Gardner, who received his M.D. degree from Yale in 1941 and is now an instructor in the Section of Preventive Medicine at Yale School of Medicine, has been assigned to an Army research laboratory in Germany to continue the joint Yale-Army investigations of infectious hepatitis. During the war this disease was called epidemic jaundice and affected troops in North Africa and Italy. During most of the year he will study in the U. S. Army Infectious Hepatitis Research Laboratory.

The appointment of Dr. Gardner was made jointly by Yale and the Virus and Rickettsial





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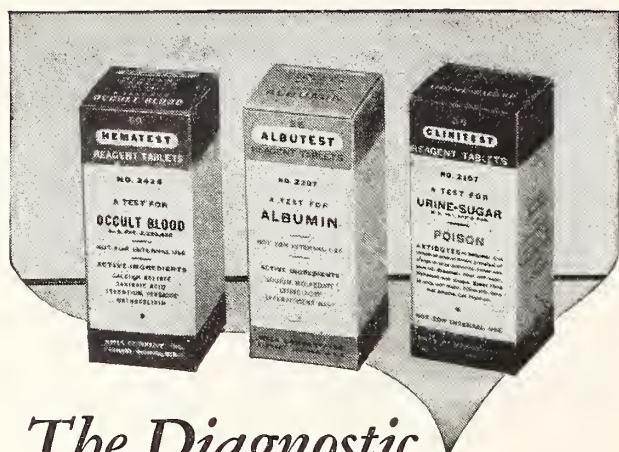
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Disease Commission of the Army Epidemiological Board. The physician is well qualified for this appointment, having served as a medical officer in the Army for four years in Burma and the European Theater of Operations. Last year he was an instructor in the Department of Public Health and Preventive Medicine at the Cornell University Medical College in New York City.

In Germany, Dr. Gardner will continue some researches with which the Yale School of Medicine has been identified since 1943 when a special commission of two members of the Yale faculty was assigned by the War Department to investigate infectious hepatitis among troops. The work of the Commission did much to explain the way in which infectious hepatitis spread and was transferred to the School of Medicine in 1944. Yale was one of the two Army laboratories for study of this disease until 1946.

## The Yale Medical Historical Library and the Sheffield Centenary

The Historical Library at the Yale School of Medicine, which has taken an active part in preparing for the Sheffield Centenary celebrations, has arranged an exhibit on the history of the sciences. Those responsible for the direction of the Library are attempting to make it a university center for humanistic studies in the history of the sciences including those which impinge upon medicine, and since the University Library is exhibiting materials on the development of science at Yale with particular reference to the background of the Sheffield Scientific School, the Historical Library has concentrated upon the evolution of the sciences in the broader sense.

The first of the Library's eight display cases is devoted to mathematical physics and includes the first edition of Newton's *Principia* (1687), Helmholtz' *Über die Erhaltung der Kraft* (on the conservation of energy published in 1847), Joule and Robert Mayer on the mechanical equivalent of heat, and Willard Gibbs' *On the equilibrium of heterogeneous substances*. Other cases include Copernicus' *De revolutionibus* (1543) and the very rare preliminary statement concerning the Copernican system published by Rheticus at Danzig in 1540; Galileo's two dialogues; Benjamin Franklin, Galvani, and Volta on electricity; Boyle, Hales, Priestley, and Lavoisier on the air, with the original announcements of Priestley and Lavoisier on the



discovery of oxygen; Linnaeus' *Systema naturae* (1735); Darwin's *Origin of species* (1859); Röntgen's discovery of the x-ray; the doctoral dissertations of Pierre and Marie Curie (1895, 1903); Einstein's first paper on the theory of relativity (1905); a large group of R. A. Millikan's writings on cosmic rays; James Hutton's *Theory of the earth* (1788); and Dana's *Manual of geology*, 1863.

At a time when the sciences have come to play such a dominant role in determining the destiny of contemporary civilization, it is believed that the historical backgrounds of the sciences should be emphasized as a part of any program of general education. The great classics, many of which are rare and unavailable, have been brought together in the Historical Library largely as a result of the munificence of the late Dr. Harvey Cushing. Since many of these early texts are unprocurable and yet in great demand by students, the Historical Library, through periodic exhibits such as that arranged for the Sheffield Centennial, hopes to arouse further interest in them and perhaps at a later date to make some of them available in a series of facsimile reprints that would be useful for students taking such courses as the one to be inaugurated at Yale next year on the Development of the Sciences.

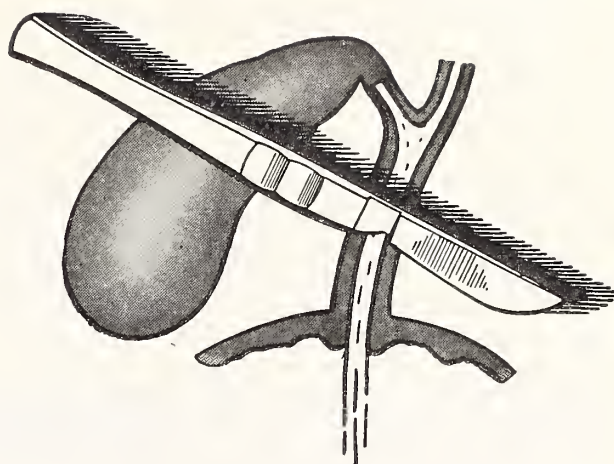
### Third Edgar Allen Memorial Lecture

"Chemical Carcinogenesis and Experimental Chemotherapy of Cancer" was the subject of the Third Edgar Allen Memorial Lecture given recently at the Yale University School of Medicine.

The lecture was delivered by Eric Boyland, sc.d., ph.d., Chester Beatty Research Institute, Royal Cancer Hospital, London, and reader in biochemistry, University of London.

The lectureship was established in memory of Professor Edgar Allen, chairman of the Department of Anatomy, Yale University School of Medicine, from 1933 until his death in February, 1943. First to demonstrate the presence of the female sex hormones in extracts of the ovary and to develop a method for their bioassay, Professor Allen's studies were instrumental in establishing the role of steroid hormones in cancer of several organs and tissues in experimental animals.

In recognition of his work, honorary doctorate degrees were awarded him by Brown University and Washington University. France awarded him the Legion of Honor, and the Royal College of Physicians of London conferred upon him the Baly Medal.



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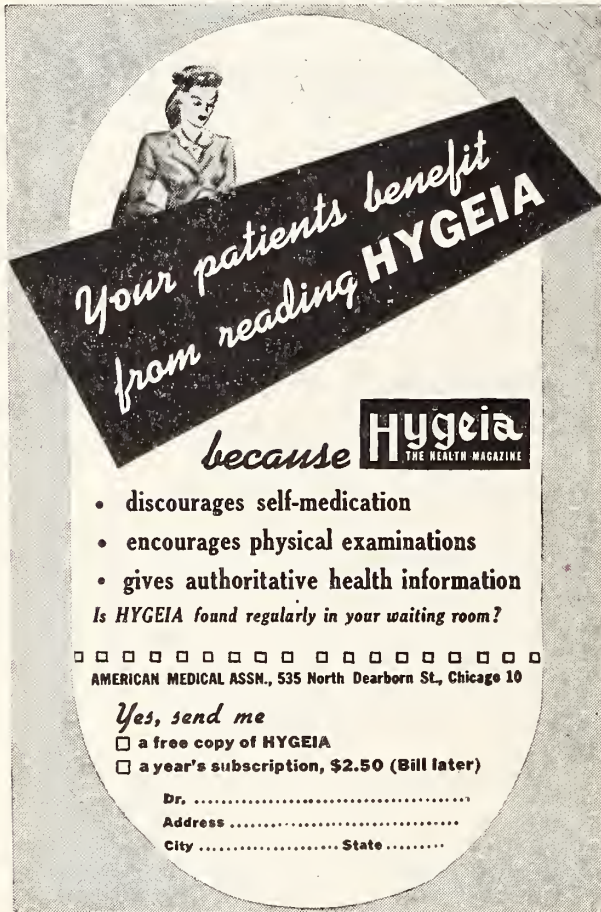
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## NEW BOOKS IN REVIEW

**INTRODUCTION TO MEDICAL PSYCHOLOGY.** By L. Erwin Wexberg, M.D., Director, Bureau of Mental Hygiene, District of Columbia. New York: Grune & Stratton. 1947. 171 pp. \$3.50.

Reviewed by JAMES M. CUNNINGHAM

The author of this book indicates in the preface that this book has been developed from scripts of lectures prepared and distributed to undergraduate students of the Louisiana State University School of Medicine. He felt the need for a written text to supplement classroom lectures and found none of the existing writings suitable for his purposes. He also hopes that this volume may fill a need for practicing physicians who wish to know something about psychological training in medicine. To the reviewer it seems unfortunate that this volume falls so far short of being a real introduction into modern concepts of medical psychology.

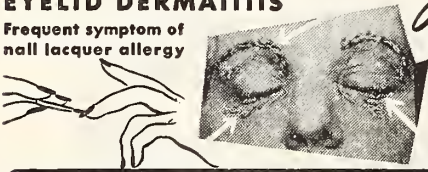
A great deal of the writings of the author represent personal conclusions and ideas of his own which are written in the form of a statement of fact. Also throughout the text there are very broad statements of a controversial character made first on one side of the fence and then on the other. It seems that these could only confuse one who had not previously had considerable background in this field of knowledge.

Insofar as being an introduction to medical psychology is concerned, the author devotes one half a page to the topic "Psychology of the Sick." Other related topics are similarly treated in such summary fashion.

A good deal of the book is concerned by the author with the development of the concept of free will and conscious responsibility for the individual's behavior and reactions. He takes primarily as his base of origin the research and theoretical work of the Pavlov, Bekhterev and Watson school of reflexology and the school of gestalt psychology. It is a little bit difficult to see how one can arrive at this concept of complete conscious responsibility for either emotional feelings or behavior as derived from this highly mechanistic theoretical base. The author is also concerned about various ethical and moral values which are treated as if they existed outside of the individuals and social groups who hold to these particular values. They are the eternal verities which the author accepts as existing in and of themselves. The book seems to be concerned with philosophical and moralistic concepts rather than with scientific discovery, analysis

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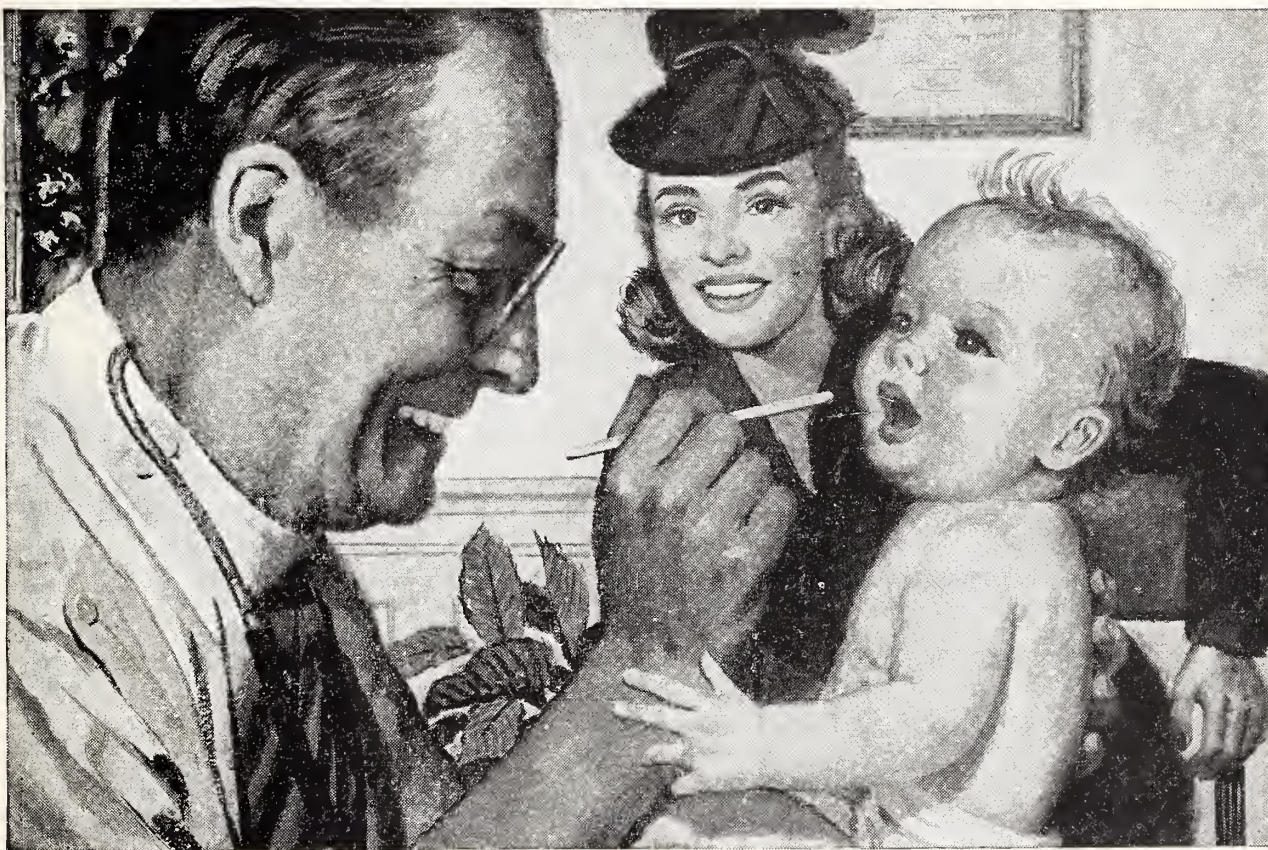
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and explanation. Only passing mention is made of the work stemming from Freud and his followers and the entire book excludes mention of the findings of this school by omission rather than any effective discussion or evaluation of either its psychiatric findings or theoretic construction.

While the author is apparently writing an introductory book for undergraduate students, he nevertheless consistently uses technical vocabulary which presupposes considerable more knowledge than can be expected of a beginning student. Also the derivations of his comments from the various schools such as Pavlov, Bekhterev and Watson and the Allport school of psychology, etc., and the brief extractions from these different sources without adequate explanations of the school of thought itself will be very difficult of understanding by a person who has not previously been oriented in these various schools of psychology.

The reviewer believes also that there are a considerable number of statements in this book which are stated more or less as fact but are subject to considerable difference of opinion and represent the personal feelings of the writer.

There is no question but that a good textbook on medical psychology written in simple, understandable English is urgently needed. The reviewer does not feel that this book meets these needs.

*A TEXTBOOK ON PATHOLOGY OF LABOR, THE PUERPERIUM AND THE NEWBORN.* (Second Edition.) By Charles O. McCormick, A.B., M.D., F.A.C.S., Clinical Professor of Obstetrics, Indiana University School of Medicine; Consulting Obstetrician to William H. Coleman Hospital for Women, Indianapolis City Hospital, and Sunny Side Sanitarium. St. Louis: The C. V. Mosby Company. 1947. 514 pp. 272 illustrations. \$8.50.

Reviewed by STANLEY B. WELD

The favorable comments made in reviewing the first edition of this textbook may be applied likewise to this, the second edition. The author has maintained the streamline plan, the concise and direct style, and the detailed therapy of the earlier edition. As that volume was up to date, so this one continues to uphold that reputation. As an outgrowth of a series of lectures prepared for medical students apparently it is one of the author's purposes to encourage further collateral reading.

There are many additions to this second edition. To the previous discussion of the various types of pelvis has been added the Caldwell-Moloy classification. The discussion of complications of the puerperium has been enlarged to include cardiac disease, diabetes, eclampsia, and sudden death. While the discussion of the first two is brief there are references to good source material. To the author's previous discussion of breech extraction is added an outline of the Burns' maneuver with accompanying illustrations. The author is a strong advocate of external version and in this edition presents his own technic, well illustrated.

Dr. McCormick pays our own Charles G. Barnum the compliment of referring to his maneuver for delivery of impacted shoulder in the discussion of the author's own method. The anticoagulants in the treatment of thrombo-

phlebitis, the use of streptomycin in the treatment of puerperal infection, and a fuller discussion of cesarean section are additions of importance. The Rh factor is dealt with in much more detail and represents an outline of the latest thought on this problem, including the treatment of the newborn with replacement blood transfusions.

The author continues to devote four pages to a discussion of rectal ether analgesia which, in this section of the country at least, seems to be outmoded, but there is included in this chapter on analgesia and anesthesia a page on demerol and scopolamine. Bed posture and exercises, early puerperal rising, and a very good chapter on religious requirements and restrictions have been added to the appendix.

This volume is excellent for its kind, containing as it does brief discussions in outline form with frequent references to more detailed articles. The illustrations, including many in color, are very good and the volume is well printed in a convenient size.

*WHAT YOU CAN DO FOR HIGH BLOOD PRESSURE.* By Peter J. Steincrohn, M.D., F.A.C.P. New York: Doubleday & Company, Inc. 1947. 191 pp. \$2.50.

Reviewed by STANLEY B. WELD

This is the sixth in a series of books by this author dealing with some of the major afflictions of life. Like the other five, it is designed for the laity and in particular for those who have the misfortune to be hypertensive, regardless of the cause. The style follows the pattern of the other volumes in its conversational form, utilizing the question and answer method and maintaining the reader's interest with illustrations from the author's own experience as an internist. The presentation of the subject is repetitious but this is done for the purpose of emphasis so that at the end there may be no doubt in the reader's mind of the author's opinions. Of the six volumes in this series none has quite equalled the first.

This last product of Dr. Steincrohn's pen affords the hypertensive individual a working formula for living within his limits. As the author states in his preface, it should transform him into "one who learns to live with and accept his disease rather than one who continues to fight against it with weapons forged in ignorance." The advice contained within its pages is timely. It is explained that the causes of hypertension are yet to be discovered. The newer surgical procedures used in its treatment are outlined, together with the use of drugs under proper supervision. One's habits are stressed as of prime importance in alleviating symptoms. The unimportance of actual blood pressure readings from day to day is emphasized. Ever since the Riva-Rocci apparatus was brought to this country from Italy by Harvey Cushing and put to use in the Johns Hopkins clinic, the inquisitive eyes of the layman have become more and more centered on the height of the column of mercury. Throughout the entire volume the author endeavors to impress the reader with the need for a better understanding of how to live.

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*NEW AND NONOFFICIAL REMEDIES, 1947, CONTAINING DESCRIPTIONS OF THE ARTICLES WHICH STAND ACCEPTED BY THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION ON JAN. 1, 1947.* Philadelphia: J. B. Lippincott Co. 1947. 749 pp. Cloth. Postpaid, \$3.

Although the latest edition of New and Nonofficial Remedies has some eleven pages fewer than the 1946 book, its increase in size, due to the heavier paper used, and its change of color—dark green to bright red—combine to make a striking contrast with the earlier annual volumes. The book is now published by J. B. Lippincott and Company, though it is still issued under the direction and supervision of the Council on Pharmacy and Chemistry. Another innovation is the relegation of the statements of tests and standards to the back of the book, which makes the text more convenient and useable for the physician, for whom it is primarily intended. It is understood that supplements to the annual volumes will no longer be issued. The physician who is interested in current acceptances can keep track of these as the descriptions are published in the Journal A.M.A., or may inquire about them by addressing the Council's office at A.M.A. headquarters. Several medical and pharmaceutical journals now carry lists of currently accepted products.

There appears to be no very extensive revision in the various general articles or chapter head discussions, although several new monographs have made their appearance and others have been revised to reflect current medical opinion. One notes the appearance of a new chapter, "Unclassified Therapeutic Agents," which includes the monographs on Gold Compounds and Iodine Compounds for systemic use. This is in line with the policy adopted some years ago of classifying accepted preparations according to pharmacologic action and therapeutic use.

Attention is called to the amplification and indexing of the section devoted to the statement of the Council's Rules. This should be of great assistance to manufacturers in the presentation of products for Council consideration and is no doubt inspired by the recent marked increase in the number of pharmaceutical concerns asking Council recognition.

The descriptions of some thirteen new preparations appear in this volume. This excludes, of course, brands or dosages of already accepted agents. Among those preparations noteworthy of mention are the pertussis vaccines and vaccines representing combinations of pertussis with diphtheria and tetanus organisms; the new histamine-antagonizing agent, Benadryl Hydrochloride Elixir (Diphenhydramine Hydrochloride Elixir); Furacin (Nitrofurazone) a new topical anti-infective agent; Streptomycin; Heparin Sodium; Parenamine, a new casein hydrolysate; Thiouracil, an antithyroid agent; Naphuride Sodium (Suramin Sodium), a new trypanocide; and Tuamine (Racemic 2-aminoheptane), a new vasoconstrictor. One notes the increasing appearance of generic designations in conformance with the revised Council's rules on acceptance of agents bearing protected or trademarked names.

New and Nonofficial Remedies remains a most valuable and authoritative compendium of modern rational thera-

peutics. With successive editions, it becomes more useful and accessible to the physician and to all those interested in the use, preparation, or manufacture of drugs.

*ANNUAL REPRINT OF THE REPORTS OF THE COUNCIL ON PHARMACY AND CHEMISTRY OF THE AMERICAN MEDICAL ASSOCIATION FOR 1946.* Chicago: American Medical Association. 1947. 135 pp. Cloth. Postpaid, \$1.

This volume was formerly of most interest to those who wished to know why the Council on Pharmacy and Chemistry had not accepted certain of the preparations it had considered. The reports were mainly those of rejection; though, through the years, the educational nature of the Council's work was attested by status reports on drugs, or therapeutic procedures, or preliminary reports on agents showing promise of usefulness but not yet ready for adoption by the general and medical profession. In recent years, the tendency has been toward a preponderance of the educational type of report. In the present volume, both the condemnatory and the educational phases of the Council's work are represented.

There are three reports of vigorous condemnation: first, the report on Cabasil, a curiously unscientific mixture whose exploitation for use in a multitude of diseases is aptly summarized by the sub title of the report, "Quackery Unlimited"; second, the report on the pseudo-scientific Ethylene Disulphonate (Allergosil brand), a preparation of highly uncertain nature exploited to physicians for use in allergic conditions; third, Formula A-N-1, a joint report of the Council on Pharmacy and Chemistry and the Council on Industrial Health, concerning an expensive but poor substitute for aspirin and citrate of magnesia, cleverly promoted to industrial concerns for use in reducing absenteeism due to colds.

Among the status reports, the excellent article of Dr. Samuel M. Feinberg, "Histamine and Antihistaminic Agents," is probably most worthy of mention. Since its appearance, the Council has accepted for inclusion in New and Nonofficial Remedies, the two new agents of this class evaluated in the article, Diphenhydramine Hydrochloride, and Tripeleminamine Hydrochloride (Benadryl Hydrochloride and Pyribenzamine Hydrochloride, respectively).

Pharmaceutical and scientific investigators, alike, will be interested in the informative report on the Council's new Therapeutic Trials Committee. Of special interest to manufacturers is a statement on the revised rules of the Council, though this exposition of the trends of Council policy is of concern to all who are interested in progressive rational therapeutics.

Attention is called to the several reports on the adoption of generic designations for drugs proposed or marketed under protected names. Not all such actions of the Council have been the subject of separate published reports; the recognized terms have appeared in the published descriptions of the drugs when accepted, and will be inserted in another Council publication, New and Non-official Remedies, as adoption of such designations for already accepted protected names proceeds.



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DECEMBER, 1947

No. 12

## SODIUM RESTRICTION IN HYPERTENSION

GEORGE A. PERERA, M.D., *New York City*

*The Author. Assistant Professor of Medicine,  
Presbyterian Hospital, Columbia University College  
of Physicians and Surgeons*

THERE is an old saying that no matter what a doctor does or does not do for a patient, the patient should feel the better for having seen the doctor. In chronic disease of any type, the avoidance of creating fear in the mind of the patient, the avoidance of unnecessary limitation or invalidism, cannot be overemphasized. Before embarking on any rigid medical or dietary program for the hypertensive subject, we are obligated to examine the evidence critically. Treatment should not be carried out just in order to do something, but should always have some reasonable justification. We should not treat the elevated blood pressure without regard for the patient who has it, or without an understanding of the highly variable natural history of the disease.

Let us look at the evidence that sodium chloride bears some relationship to hypertension. Restriction of salt intake as a therapeutic measure in hypertensive vascular disease was first advocated many years ago by Volhard, Ambard, Allen and others. Although subsequent investigators claimed that the addition or removal of salt from the diet failed to alter the blood pressure significantly, interest in the subject has been recently renewed. Selye and his co-workers<sup>1</sup> noted a striking hypertensive effect when sodium chloride was administered to experimental animals receiving injections of desoxycorticosterone acetate. Grollman and his associates<sup>2</sup> observed that drastic reduction in sodium intake resulted in a decline in blood pressure in some hypertensive patients. They believed it probable that the beneficial effects of the diet proposed by Kempner<sup>3</sup> might be due to restriction of salt. Recently Knowlton and her

collaborators<sup>4</sup> presented evidence that sodium chloride potentiates the pressor activity of desoxycorticosterone acetate when injected into experimental nephritic animals.

For the past three years we have been studying patients with uncomplicated hypertensive vascular disease at the Presbyterian Hospital in New York, primarily because of interest in a possible adrenal cortical relationship. Patients were selected without complications, that is, they gave no laboratory or clinical evidence of cerebral, cardiac or renal involvement. It was found essential to have a baseline of at least three weeks before embarking upon experimental procedures. Often the mere admission of a patient to the hospital, even though ambulatory and without any other change in regimen, would result in a marked drop in blood pressure without any specific therapy of any kind. The "resting" as well as the "casual" blood pressure were recorded. By "resting" values we mean the blood pressure taken by the same observer, in the same arm, in the morning with the patient lying in bed, with a minimum of five and usually seven or eight readings, and the lowest systolic and diastolic pressures recorded. It was observed that the "resting" blood pressure closely approximated the basal readings that one may obtain with sodium amytal. By "casual" blood pressure is meant any casual reading with the patient in bed, sitting in a chair, or at different times in the day under different conditions of activity.

The patients studied were placed on identical daily menus, the diet containing from .7 to .8 grams of sodium chloride a day. To this we were able, as we chose, to add fixed amounts of salt in weighed shakers. Throughout the study the patients were on a constant fluid intake. Periodic chemical and laboratory studies were carried out.

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Slight but consistent effects of rigid salt restriction were observed in six hypertensive subjects. Following the establishment of a baseline, sodium chloride was restricted for a period of two weeks, and in all instances there was a drop in "resting" blood pressure. The majority of readings, however, remained above normal. A few patients felt slightly improved subjectively or noted relief of headaches. Others observed no subjective change. "Casual" blood pressure readings were unaffected by salt restriction; the patients still exhibited the same response to emotional reactions, activity, apprehension, or cold pressor test, as they demonstrated before the rigid restriction of salt. It was found that hypertensive subjects could tolerate this diet for long periods. With sustained restriction there was slight weight loss and small increases in urinary output, but no significant change in blood chemistry, in blood volume, or cardiac output.

Following a baseline period in which there was a daily ration of four grams of salt, six hypertensive patients were given fifteen grams of salt per day, and in five subjects there was a slight increase in the "resting" blood pressure. Again casual readings were uninfluenced.

The effect of rigid sodium chloride restriction on the pressor action of desoxycorticosterone acetate was then tested in five patients. It has been previously shown that the rise in blood pressure that may follow the administration of this steroid in normal subjects or in patients with Addison's disease is not entirely explained by retention of salt and water, but by adding or restricting salt it was demonstrated that the pressor response is apparently dependent on the sodium chloride intake. When desoxycorticosterone acetate was injected and the diet contained four grams of salt or more, the blood pressure rose. When all the added sodium chloride was removed from the diet, leaving the patient with the basal diet of between .7 and .8 grams of sodium chloride, the blood pressure fell. As it was occasionally observed that the pressor response to desoxycorticosterone was transitory, in several patients the studies were reversed with rigid sodium chloride restriction started at the same time as desoxycorticosterone was administered. No change in blood pressure took place until the addition of sodium chloride.

Lastly, the effect of twenty-four hours of rigid sodium chloride restriction in normotensive and hypertensive subjects was studied. After a baseline period ten individuals without hypertension were

placed on rigid sodium chloride restriction for one day. Within twenty-four hours there was an average weight loss of one kilo and an average increase in urine output of 500 cc. Some of the patients noted an increased sweat production. When rigid salt restriction was continued for longer periods, several subjects began to have symptoms of salt depletion—fatigue, cramps, loss of sense of taste, and weakness. On the other hand, twelve hypertensive subjects placed on twenty-four hours of rigid sodium chloride restriction did not respond in the same manner. There was no conspicuous weight loss, no obvious diuresis, and it was found possible to maintain a hypertensive subject on this diet for periods of months without any significant symptoms appearing. This suggested a disturbance in salt and water metabolism in hypertensive vascular disease, perhaps of renal origin, perhaps mediated through the adrenal cortex.

What may we conclude from these studies, from Grollman's work, and Kempner's reports of the rice diet? It is clear that sodium chloride has a slight but consistent effect on the blood pressure of some hypertensive patients, but brought out in our hands only by measuring the blood pressure carefully under "resting" conditions, and only achieved when the salt intake was drastically restricted. It is also clear that therapeutic results must be carefully evaluated. We have seen hypertensive subjects admitted to the hospital for study after repeated blood pressure recordings never below 170/110 whose blood pressure fell to an average level of 110/60, only to rise again after leaving the hospital. The great variability of blood pressure readings in association with any of a large number of environmental changes makes it obvious that a careful baseline is obligatory before carrying out any type of investigation or therapeutic study. There are indications that some disturbance in salt and water metabolism exists in hypertensive vascular disease. The absence of any correlation between the "resting" and the "casual" blood pressure suggested that neurogenic vasoconstrictive mechanisms, such as are modified by sympathectomy, may be separate from alterations in peripheral resistance modified by salt and steroids. It still remains to be seen whether therapy aimed at reducing the blood pressure in any way alters the life history of this variable disease. It has been repeatedly demonstrated that the level of the blood pressure and the complications of hypertensive vascular disease are unrelated.



All of this provokes a few questions. Should one restrict salt in the treatment of the hypertensive patient? Until more is known about mechanisms it seems justifiable to avoid large quantities of salt. As a proven cure of established benefit, there is as yet no conclusive evidence. As a therapeutic trial in some hypertensive subjects, rigid sodium chloride restriction may be justified in rare instances but only when the limitations imposed by this diet are weighed against the possible and uncertain benefits.

What is the easiest way of achieving rigid salt restriction? It can be done without any special ingredients by using regular food prepared without salt. The diet may include meat and eggs daily, or small portions of meat twice daily, the use of fruit and vegetables, the latter steamed or boiled repeatedly. To this diet one may add liberal amounts of salt-free butter and salt-poor bread but milk or cream should be avoided except in minute quantities. As to the palatability of this diet, it is often well tolerated in a hospital environment, but much more difficult to carry out for long periods in the home. We have found that the use of mustard, pepper, and glutamic acid may improve the taste.

Are there any advantages to the rice diet? It may prove interesting to see what effects on protein, cholesterol and nitrogen metabolism are achieved after long periods on a diet such as the rice and fruit diet proposed by Kempner. There may be some place for this diet in some patients with congestive failure, in some patients with renal disease. As far as

uncomplicated hypertensive vascular disease is concerned, we have been unable to demonstrate any effect beyond that produced by salt restriction in ten patients who had faithfully remained on the diet for periods of at least two months. The slight drop in blood pressure could be completely obliterated by the mere addition of sodium chloride to the diet. At present it would appear that this form of diet may lead to limitations far out of proportion to its value.

In summary, it appears that sodium chloride is related in some way to the mechanism of hypertensive vascular disease. Its restriction as a therapeutic measure is still on a trial and experimental basis, the harm of such limitation and dietary invalidism often exceeding the benefit. It remains to be seen as to the effects of rigid salt restriction on the natural history of the disease.

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## A DISCUSSION OF THE TREATMENT OF FUNCTIONAL DYSMENORRHEA AND A HORMAL TEST FOR ENDOMETRIOSIS

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**E**NDOMETRIOSIS is a subject about which little was known prior to the work of John A. Sampson<sup>1</sup> and that of Emil Novak.<sup>2</sup> Since then several excellent papers have been written from the clinical viewpoint, among these the most notable and instructive are those of A. H. Morse<sup>3</sup> and Virgil Counsellor and F. S. Slater,<sup>4</sup> both of which papers outline very comprehensively the vagaries of ectopic endometrium and evaluate the surgical skill and judgment necessary in treatment especially in situations which all too frequently are unfortunate from

the point of view of preserving the patient's reproductive system.

There are in general two types of endometriosis: (a) internal, which invades the uterine musculature and (b) external, which invades the serosa of the tubes, ovaries, the peritoneum of the cul-de-sac and utero-vesical pouch, the rectum, the sigmoid, the appendix and the mesentery of the large and sometimes the small bowel.

External endometriosis is definitely not cancer. In internal endometriosis, cases of malignant degen-

eration in adenomyosis of the uterine wall have been reported by C. A. Castano<sup>5</sup> in 1940, Cirio<sup>6</sup> in 1933, and frequently endometrial implants in the recto-sigmoid area have been mistaken for cancer. Most surgeons are now aware of the possibility of endometriosis in this area and more frequent frozen sections have prevented a great deal of radical surgery. The majority of endometriosis that is seen, however, is the external type, implantation around the tubes and ovaries and in the cul-de-sac. Goodall<sup>7</sup> has written two editions of a monograph on endometriosis. He very carefully describes variation in cellular structure into three types, Stromatous Endometriosis, Stromatous Endometriomata and Acute Endometriosis. He concludes, however, that the terms are purely relative, and calls the first two, the chronic stages, those where cells lose their productive forms and become streamlined into more mature and even senile types. However, he concludes that the disease which occurs between the age of 23 and the menopause is a disease arising out of a neglected function of reproduction and is a product of our civilization due to late marriages and later conceptions, because so often endometriosis is seen after long periods of infertility after conception. Nevertheless, the same author states that ovaries afflicted with endometriosis are in his opinion "unusually prolific ovaries filled with ova and with the products of developing matured with defective follicles."

Why these discrepancies? Is it possible that the cause of this prolific hyperplasia of ectopic endometrium has its inception in functional hormonal changes that may occur after pregnancy as well as in the female whose reproductive functions have been thwarted by late marriage? Curiously enough, both these situations seem relatively frequent in reviewing the cases of endometriosis with which I am familiar.

Although the symptomatology of endometriosis has always been associated with menstrual function, reports of the effect of hormones on this disorder are rare. Morse<sup>3</sup> concludes his paper with the advice that the use of estrogenic therapy after operating upon cases of endometriosis is better avoided if possible, as the implants remaining may be thus activated. Goodall<sup>7</sup> states that the "acute" types of endometriosis "bespeaks an active, powerful agency stimulating specific cells to growth and to a capacity to break through the bounds of normal environment." He further postulates, "we are reduced to considering the endocrine functions of the ovary

as the immediate cause of endometriosis and its allied diseases—most of the manifestations accompanying endometriosis are of the nature of hypertrophies and—hyperestrinization is another interesting clinical feature." Yet despite these theories, nowhere does Goodall present any data on the effect of hormonal stimulation on the clinical picture. Recently, in 1944, James R. Miller<sup>8</sup> wrote a paper on the effect of testosterone in reducing the size of endometrial implants in the cul-des-sac and the sigmoid preliminary to performing a radical operation on the recto-sigmoid. John C. Hirst<sup>9</sup> in 1945 reported that testosterone-propionate therapy had improved the symptoms of fourteen patients with endometriosis both external and internal. He gave a monthly maintenance dose of 300 to 400 milligrams of methyl testosterone per os following one month in which 200-300 milligrams were given intramuscularly. He reports masculinization symptoms, however.

If testosterone gives such good results in deactivating the ectopic endometrium, it seems reasonable to believe that hyperestrinization could be used as a diagnostic agent. No natural hormone hypodermically causes any "explosive" reaction physiologically and, as a rule, two or three months elapse before primary functions are appreciably affected. As early as 1940, Fuller Albright<sup>10</sup> described the mechanism of estrin therapy in the relief of dysmenorrhea. In certain cases of functional dysmenorrhea, Sturgis and Albright<sup>10</sup> showed that the presence of a normal corpus luteum is a prerequisite for the occurrence of dysmenorrhea and hyperestrin therapy prevented cramps by arresting the development of a functioning corpus luteum during that cycle. To quote, "This study is based on a series of twenty-five cases. These patients with one or two exceptions had severe distressing dysmenorrhea frequently forcing them to miss one to three days from their work." Throughout the study, the patients received 10,000 units of estrodiol-benzoate intramuscularly every third day. A series of injections consisted of from three to fourteen. "It was soon apparent that the immediate result of a series of such injections depended entirely upon how soon in the month the injections were started. If the first of a series of from six to twelve injections was given within the first week after the onset of menses the next period was invariably free from cramps. If the series was not started until two weeks after the onset of the previous flow, there was no change in the pains during the subsequent bleeding. It was next noted that



although a completely cramp-free period followed a course of estrin given early in the cycle, yet the next period, if the course of estrin was omitted, was just as painful as ever."

Needless to say, these authors then took endometrial biopsies and proved that these patients with essential dysmenorrhea had secretory endometrial patterns, evidence that ovulation had taken place. When endometrial biopsies were taken after an early series of estrin injections, the endometrial biopsy before the following cramp-free period showed a proliferative pattern, evidence that corpus lutein formation was repressed. In the same manner, endometrial biopsies in a succeeding month without further estrin therapy showed that estrin treatment one month did not repress or inhibit ovulation the next month.

The author first became aware of this method of treatment at a meeting of the New England Obstetrical and Gynecological Society in Boston in 1940 and soon after had a series of cases numbering about twenty on whom this treatment was instituted for essential dysmenorrhea with marked success in the majority of cases. One patient was seen however, whose dysmenorrhea under this type of estrin therapy gradually increased instead of diminished. Endometrial biopsies were taken on this patient and she showed the usual proliferative phase suggestive of repressed ovulation due to early cycle administration of estrin. The dose of estrin given was increased to 20,000 units every other day for the first ten days after menses stopped and gradually, with the proliferative endometrium persisting, the patient's pains instead of diminishing, increased. Pelvic examinations shortly after the cessation of each painful period showed a gradual thickening of the adnexal structures and finally a sensation of small nodular infiltration was appreciable on palpating the cul-de-sac. It was concluded that here was a case of endometriosis where hyperestrinization had caused an arresting of corpus luteum formation but such a proliferative reaction in the ectopic endometrium that dysmenorrhea and signs of active induration in the adnexal regions resulted. This patient was operated upon and a diffuse endometriosis was found involving the cul-de-sac, both ovaries with chocolate cyst formation on the right and numerous small punctuate implants on the mesentery of the sigmoid and caecum. The patient was over 35 and with the extensive pelvic lesions, a complete pelvic operation was performed—supravaginal hysterectomy—bilateral salpingoophorocystectomy

and appendectomy. Recovery was prompt and within two months the patient had climacteric symptoms which were not severe but prolonged for about a year. The best method of treating this complication is to give about 2000 units of estrin hypodermically twice a week until all the symptoms are minimal over the entire weekly interval which usually takes six to ten weeks and then give about 2000 units of a natural oral estrogenic hormone twice a week for about a year. Usually the oral hormone is not sufficient and every three or four months a dose of 2000 units hypodermically weekly for a month completely alleviates symptoms. After 12 to 18 months the patient usually can discontinue all medication. Occasionally, however, patients have to continue estrin therapy for four or five years before their secondary symptoms are completely alleviated especially where castration is necessary before the age of 30 for extensive endometriosis. As case reports will show, however, I do not think that radical surgery is indicated before the age of 30. In no instance has mild, natural estrogen therapy caused a recurrence of pelvic or abdominal pain after radical operation for endometriosis. Three cases have been seen however, who left the author's care and were given oral ingestion of stilbesterol which is a synthetic estrin in daily doses as high as 5 milligrams. All three after taking this amount of synthetic estrogen for several months to two years, had recurrence of abdominal pain more or less cyclic in nature and showed thickening around the cervical stump on reexamination. Deep x-ray therapy promptly relieved symptoms after about six weeks and further mild treatment with natural estrins if indicated, gave no untoward symptoms.

The interesting feature of the case described above was the part that estrin therapy played in bringing out the physical signs of endometriosis. This phenomena has been verified in other cases. The dominant symptom in endometriosis is dysmenorrhea—the amount of pelvic induration is a variable factor and from a clinical point of view, marked induration in the cul-de-sac or adnexa indicates that the disease has progressed to a point where operative interference will probably be necessary. In the course of treating a large number of cases of what appeared to be functional dysmenorrhea after the method described by Fuller Albright,<sup>10</sup> the author discovered six more patients whose dysmenorrhea became more severe after estrogenic injections in the early intermenstrual phase and in three of which pelvic induration became pronounced

exploratory operation verified the endometriosis. In one patient, aged 32, a supravaginal hysterectomy and a bilateral salpingoophorectomy was necessary with the same post operative result described in the first case. The other two both had endometrial implants in the ovary on the right, one with small chocolate cyst formation and several small endometrial implants in the cul-de-sac and utero-vesical areas. In these cases a dilatation and curettage was done and a removal of the right tube and ovary and as much of the implants as possible; the appendix was also removed, leaving the uterus and the left tube and ovary intact. For two or three months afterward both these women who were in their late twenties were treated with testosterone 25 milligrams hypodermically twice a week over three periods after the operation. Periods were resumed without any pain and after three months, the patients required only 25 milligrams testosterone hypodermically ten days before each period. One year later, one became pregnant and carried to term with delivery by low forceps and episiotomy. The child was a normal female, 7½ lb. infant and the mother had a normal puerperium followed in three months by resumption of normal periods and no painful menses since with check-up every six months over the last eighteen months. The other case in this group did not return for examination for about a year at which time she was again beginning to have dysmenorrhea. She had slight induration and tenderness around the left ovary and the author diagnosed a return of endometriosis in the left adnexal region. Testosterone 25 milligrams hypodermically twice weekly for two months slightly alleviated her dysmenorrhea, but the induration in the left adnexal region persisted and it was feared discontinuance of therapy would result in adnexal pathology sufficient to require further operation. It was decided to treat this patient with about 1000 R deep radiation to the left ovary. This was done and within six weeks the left adnexal region was free of induration and tenderness. Her periods had ceased but she curiously had no symptoms of the climacteric. Her inclination for follow-up since has been just as poor as after her operation but it is felt that if she were complaining she would return.

The other three cases where estrogenic therapy increased the severity of the dysmenorrhea showed no gross changes in the pelvis and it was presumed these were either internal endometriosis or if external not progressed to a pathologic stage. In these three instances, therapy was transferred to testo-

sterone 25 milligrams hypodermically twice a week over a period of two or three months, at the same time dilating the cervix and introducing a uterector (Bley Corp) after measuring the utero-cervical index. Three months of therapy sufficed to clear up the dysmenorrhea and 25 milligrams of testosterone ten days before each period continued the relief. After six months the uterector was removed and at present the patients are all singularly free of complaints with 25 milligrams of testosterone once a month. One of them is now four months pregnant.

It is interesting to note that this type of testosterone therapy does not cause masculinizing symptoms and in two cases has not interfered with pregnancy. This same result has been noted in treating cases of climacteric bleeding which usually occurs between the ages of 38 and 45 and without any evidence of pelvic pathology, the periods become excessive and clotty. It seems likely that many women presenting this symptomatology have been called precancerous, and hurried to operation. The adnexal regions and uterine size and position and the cervix being normal if this symptom is reported early (within two months) all that is necessary to treat the case is testosterone in 25 milligram doses hypodermically twice a week for two months. The condition not only subsides, but several of these women have reported 6-12 months later pregnant to their utmost chagrin. If two months treatment does not completely alleviate the symptoms or if the uterus is enlarged in the utero-cervical index, or the cervix badly everted and eroded, a dilatation and curettage and conization of the cervix with Hyem's electrode and insertion into the uterine cavity of 2000 milligram hours of radium will completely alleviate the condition and the subsequent recovery is apparent after six weeks, the climacteric reaction being surprisingly mild and easily controlled, much more easily than after the supravaginal hysterectomy with bilateral oophorectomy. It is also noteworthy that in this late period of menstrual life when hyperestrinization is common endometriosis, if found, is most proliferative with large chocolate cyst formation.

Apropos of the results in treating the dysmenorrhea of the mild cases of endometriosis by testosterone and the insertion of a uterector the apparent relief by the combined method led the author to combine both estrogenic treatment and the uterector in the succeeding cases of functional dysmenorrhea. As Albright and Sturgis<sup>10</sup> noted that "although a completely cramp-free period followed a course of



estrogenic treatment if started early enough in the cycle, yet the next menses when no estrin had been given, was as painful as ever." It was therefore necessary to keep these treatments up for several months to get any prolonged relief and then after a month or two, dysmenorrhea became as severe as ever. The idea was then conceived of combining the uterector insertion with the Albright hormonal treatment for a period of six months. At the end of this time, the uterector was removed and the estrin therapy discontinued. In all, eighty-two cases have been so treated. Fifty patients or 60 per cent of these women have complained of no further dysmenorrhea for a period over one year. Many of these have been married in this interval and several are already pregnant. The other 40 per cent have had some dysmenorrhea after periods of about six months, but all of them claim the cramps are much less severe and non incapacitating and only one or two have asked for continuance of estrogenic therapy.

In using uterectors the utero-cervical index must be measured. This is conveniently done with a little sliding apparatus on a special probe which indicates in centimeters the distance from tip to the indicator which is placed against the external os. Two measurements are taken from the external os to the internal os and from the external os to the fundus uteri. In selecting a uterector care must be taken to have the wide part of the instrument well beyond the internal os and no discomfort is experienced from the presence of the foreign body. Occasionally the wearing of an uterector no matter how carefully fitted seems to create a continuous spasm in the uterine musculature and causes so much discomfort that it has to be removed. Sufferers from dysmenorrhea who are so handicapped by over stimulation of the uterine musculature are the true candidates for such operations as presacral sympathectomy if treatment is so intractable that the dysmenorrhea incapacitates them during the menses. Out of two such persons in this series, two presacral sympathectomies have been performed following this indication within the past five years. The first patient after presacral operation had painless periods for one year, then became pregnant and carried to term. She went into labor spontaneously and although labor was prolonged she dilated without any pain and after a twenty-four hours first stage was delivered of a normal six pound female child by mid forceps (Scanzoni) and episiotomy. Last year, two years after the first delivery, she had a

second pregnancy in another State and again a long labor with forceps extraction. The baby did not survive.

The second patient who had presacral sympathectomy was an unmarried girl of 18 years who was a music student. Her periods were originally so painful that she collapsed from the pain and had to be confined to bed for twenty-four to forty-eight hours. All conservative treatment with hormones and uterector failed. After operation she had one more severe period and then has been pain free for a period of two years.

Another condition which may promote endometriosis is congenital deformity in the pelvis with obstruction to menstrual flow. A twenty-two year old graduate nurse was seen last year with a complaint of increasing dysmenorrhea of two years' duration. Her periods began at 15 and until 20 were practically pain-free. Then she began to have dysmenorrhea until she had to be confined to bed the first three days of each period. Sedatives were ineffective. Rectal examination showed that she had a single cervix and what appeared to be an infantile uterus with two thickened masses suggestive of enlarged tubes in either adnexal region. In the absence of any temperature reactions or history of infection, it was considered that these swellings were either a congenital uterus or an advanced endometriosis of the ovaries. The patient refused vaginal examination under anesthesia. The use of estrin as outlined above for two months made the dysmenorrhea more severe. The use of testosterone 25 milligrams weekly gave no relief either. Finally the patient consented to examination under anesthesia and exploratory laparotomy. On vaginal examination a narrow vault with a septum on the left made a congenital deformity a distinct probability. There was a single cervix, however, and probing showed the uterine body to the right and a mass felt in the left adnexa was thought to be tubo-ovarian. Exploratory laparotomy showed a complete uterus bicornuis didelphys with several adhesions around the left ovary which were associated with mild endometriosis. Several small implants with dark centers, the largest .5 centimeters in diameter were noticed on the surface of the left ovary and on the peritoneum of the cul-de-sac. The development of both horns of the uterus was equal and both were symmetrical. Both tubes were patent to gentle probing. Accordingly the endometrial implants were carefully dissected free and while it was assumed that in an extensive congenital deformity such as this the

uterus was probably supplied through the uretral sympathetics as well as the presacral, nevertheless a presacral sympathectomy was performed. Recovery was rapid but the succeeding periods were just as painful as if no operation had been performed. Testosterone was given in 25 milligram doses weekly and still there was no effect on the dysmenorrhea. Most of the discomfort seemed to be left-sided since the operation however and remembering that the endometriosis had been around the left tube and that dilatation and curettage before the first operation had allowed probing of the right horn of the uterus it was felt after three months of poor postoperative result that the uterus should be studied with lipiodol injection. The patient was willing to have further studies made and under sodium pentothal anesthesia the cervix was exposed and drawn into working position with a tenaculum. The right horn of the uterus was easily probed with a uterine sound but with no type of probe could the opening to the left uterine horn be discovered nor was any other aperture into this side found. After about fifteen minutes of futile probing lipiodol was injected into the cervix through a cervical canula under about 180-200 millimeter pressure of mercury. About 8 cc of oil was injected for the first plate and 14 cc for the second. The finished plates showed the right uterine horn and the right tube patent but no oil had entered the left horn or the left tube. Evidence was now conclusive that the drainage from the left side of this congenital uterus was blocked and that the endometriosis found at operation was due to a retrograde spill through the left tube due to inability of the endometrium to pass in the normal direction. Whether the progressive dysmenorrhea was the result of gradual blocking of the imperfect cervical aperture from the left horn by endometriosis or whether the left horn developed later in this girl than the right and then tried to function with a blind os is a matter of conjecture though the amount of induration in the cul-de-sac rather favored the fact that the endometriosis caused completion of the block. With the evidence of complete lack of function on the left and the danger of endometriosis becoming so extensive as to interfere with the function of the right side this patient was encouraged to allow the removal of the left horn and adnexa if pathological, and promised to preserve the functioning side in the hope of eventual pregnancy.

Accordingly the old scar was excised under continuous spinal anaesthesia and the abdominal cavity opened without difficulty. There were very few

adhesions. The two horns of the uterus were still the same size although numerous fresh areas of endometriosis were present around the left ovary and in the left broad ligament. There was a large indurated area of endometriosis in the cul-de-sac near the portion of the lower left uterine segment which originally contained the os and cervical canal. The right side was singularly free of endometrial implants. The left horn was grasped with a tenaculum and drawn upward and medially. The broad ligament was very short. The left ovary contained one small chocolate cyst and several small endometrial implants. The left round and infundibulo-pelvic ligaments were tied separately with two chromic and divided to the utero-cervical junction. Here some difficulty was encountered in finding the uterine arteries. One was finally located anteriorly, a branch of the cystic vessels, and another came posteriorly and was evidently a branch of the inferior mesenteric. The left ureter was at the base of the leaves of the broad ligament and care was taken not to injure it. By keeping close to the lower segment, the vaginal vault was opened. The bladder flap was dissected free across the bridge of the uterus didelphys and pushed downward by blunt dissection. The lower segment of the left uterus was freed by blunt and sharp dissection including that mass in the cul-de-sac which appeared to be an endometrial implant. The entire left side of the congenital uterus was then dissected from the right portion close to what appeared to be the cervical portion of the right horn. The uterine arteries were transixed and tied and the vaginal vault closed with interrupted chromic sutures. The left round and infundibulo-pelvic ligaments were transixed to this portion of the vault with No. 1 chromic and sulfanilimide powder introduced over this closure. The bladder flap was drawn over the area with a mattress suture of No. 1 plain. As many of the endometrial implants as possible on the left side were freed by sharp and blunt dissection with a scissors. All visible endometriosis areas were removed. While it was impossible to feel that all endometriosis in this area was thus removed, it was felt that the remainder might be controlled by the esters of estrin. The right horn and tube and ovary were left in situ. Further exploration was negative and the abdomen was closed routinely. Seven days after the operation the patient had her first painless period in two years. 25 milligrams of testosterone were used weekly the first two months and although the endometriosis is not all gone it plays an insignificant part in the picture



now that the real obstruction has been removed and the right uterine horn is functioning normally; nor will it be a troublesome factor unless some physiological hyperestrinization overcomes the neutralizing effect of the testosterone. An endometrial biopsy in the last pre-menstrual period showed a normal early secretory endometrial pattern with beginning vacuolization of the basal portion of many of the glandular cells.

The total number of cases of functional dysmenorrhea which the author has observed over the past five years has been between 80 and 90 a year, or conservatively, about 400 cases. Among these, treatments with estrogenic hormones brought about the discovery of seven cases of relatively early endometriosis. During this same period, thirty-five cases of endometriosis have been seen, most of which were associated with extensive pelvic pathology requiring operative treatment.

The chief reason for this report, however, is to emphasize this apparent hormonal relationship between dysmenorrhea and endometriosis. It seems diagnostic to the point that in all cases of severe dysmenorrhea if estrogenic therapy as outlined plus improved pelvic drainage does not relieve dysmenorrhea in a period of three months, but instead gradually increases the dysmenorrhea, endometriosis in the absence of gross pathology is the obvious cause. Simple retroversion is not considered gross pathology. The fact that a hyperestrogenic reaction aggravates the symptoms and if prolonged may give palpable evidence of pathology as well as the fact that the neutralizing effect of testosterone improves the symptoms seems to prove that the endometriosis that we see in the operative stages has been the outcome of a prolonged functional hyperestrogenic reaction the nature of which it is imperative that we discover in order to save the reproductive function. That means that we should have some method developed to measure serum estrins and gonadotropins, as we measure sugar or npn. So far the methods employed are not practical for routine clinical employment. While the cause is still obscure, however, I feel confident to say that the effect of the above estrogenic hormonal reaction by increasing dysmenorrhea is diagnostic of the presence of the disease in its early stages, and as such, the early diagnosis should be made more often. The approximate ratio, one to sixty, in cases of dysmenorrhea does not make the incidence so obscure as to prevent a good effort to investigate every case of functional dysmenorrhea. While the peculiar anatomy of the

female reproductive organs makes it possible for endometrium to accidentally pass through the tubes as well as the cervix, and the frequency with which large open sinuses and lymphatics in the course of menstruation or pregnancy invites the same type of invasion through circulatory channels, the ratio of potential cases of endometriosis may be far greater than one to sixty, yet it is certain that some explosive hormonal reaction sets it off. Whether this originates in the ovary or in the pituitary through the follicle-stimulating gonadotrope remains to be seen. This reaction, moreover, is a relative reaction in the economy of the individual—it falls where it may whether the individual be married or unmarried, whether civilization is what it is or used to be in other ages. It will be corrected not by urging women to marry younger and have more children but by newer diagnostic methods of determining quantitatively the hormones circulating at any given time and how they are influenced by internal and external reactions in this colloidal suspension that keeps our system in tune. Earlier diagnosis will also enable effective neutralizing substances like testosterone to be effective in smaller studied doses and in the end endometriosis, like functional menopausal bleeding will be treated by hormonal regulation and not by surgery.

#### CONCLUSIONS

Dysmenorrhea is a symptom complex of several disorders from which potential cases of endometriosis must be diagnosed early, and if possible, before pelvic spread of the implants makes extensive pelvic operations necessary. After pelvic examination every severe dysmenorrhea unassociated with gross pathology, after the age of twenty should be treated first by hormonal therapy of about 50,000 units of estrin or estradiol hypodermically in the first two weeks post menstrual, combined with the insertion of a satisfactory form of stem pessary for adequate pelvic drainage as well as for mild stimulatory effect on the uterus. This treatment should be continued for about six months before removing the pessary. After two or three months' treatment, dysmenorrhea in most cases will disappear. If, over a three month period, dysmenorrhea increases instead of disappears, the presence of internal or external endometriosis should be suspected—even without any evidence of pelvic pathology on bimanual palpation, either vaginally or rectally. This will occur in about one out of sixty cases of dysmenorrhea and these patients should be immediately transferred from estrogenic therapy to testosterone

25 milligrams hypodermically twice a week for three months. After this period of time the pessary can be removed and the testosterone given 25 milligrams hypodermically about five to ten days before each period. This will so modify estrogenic action that hypertrophy of the endometrial implants is inhibited and in the author's experience, no masculinizing effects are noticeable and pregnancy can still occur. This routine gives an excellent opportunity for early cases of endometriosis to be detected and controlled before extensive pelvic alterations occur and will not only decrease the necessity for surgical interference but does not prevent the superimposing of reproduction. The refinement of quantitative hormone studies in the future will bear out these findings and probably simplify the procedures necessary to detect the presence of endometrial implants.

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## INDUSTRIAL NOISE AS IT AFFECTS HEARING

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## 1. INTRODUCTION

It is amazing that there should be difference of opinion as to whether noise is annoying, disturbing, or capable of producing deafness. Nonetheless, controversy has existed. Experience with boiler-makers, locomotive workers, in the textile industry, with air hammer operators, and the like, has clearly shown that a problem exists in certain of these situations. Failure to recognize this has been due to a number of factors: first, ambiguity in understanding of what constitutes loss of useful hearing and how it should be measured; second, the relatively recent development and standardization of satisfactory instruments for measuring loss of hearing; third, the attitude on the part of many that the situation is better off if not investigated, since to do so would merely emphasize and invite attention to a poorly defined condition; and in addition, a rather strange reaction on the part of workers, who avoid the issue for fear it will bring about loss of employment or adversely effect tenure. More recently the

question has been raised as to the compensability of loss of hearing from industrial exposure to noise. This has resulted in a very considerable general awakening of interest. Investigations in the war years of the characteristics of the hearing loss from sustained high noise levels and from the repeated trauma of gun blast have established the similarity of the character of deafness from these causes. Sound levels of from 90-120 db. have repeatedly been shown to be capable of causing temporary and permanent loss of hearing under experimental conditions and levels of this order of intensity are frequent in some industries; notably in boiler-making. I think we may accept without reservation that a potential problem exists, and that deafness can result from high noise levels in industry and elsewhere.

One should not be content, however, merely to accept the existence of the relationship; but more knowledge should be sought concerning the characteristics of the hearing loss and its pattern of onset; and careful definition of methods of measurement must be made.

Interpretations are complicated by the multitude



MEAN AUDIOGRAM OF MEN  
EXPOSED TO HIGH NOISE LEVELS  
FOR FROM FOUR TO THIRTY MONTHS.  
RANGES OF IMPAIRMENT SHOWN

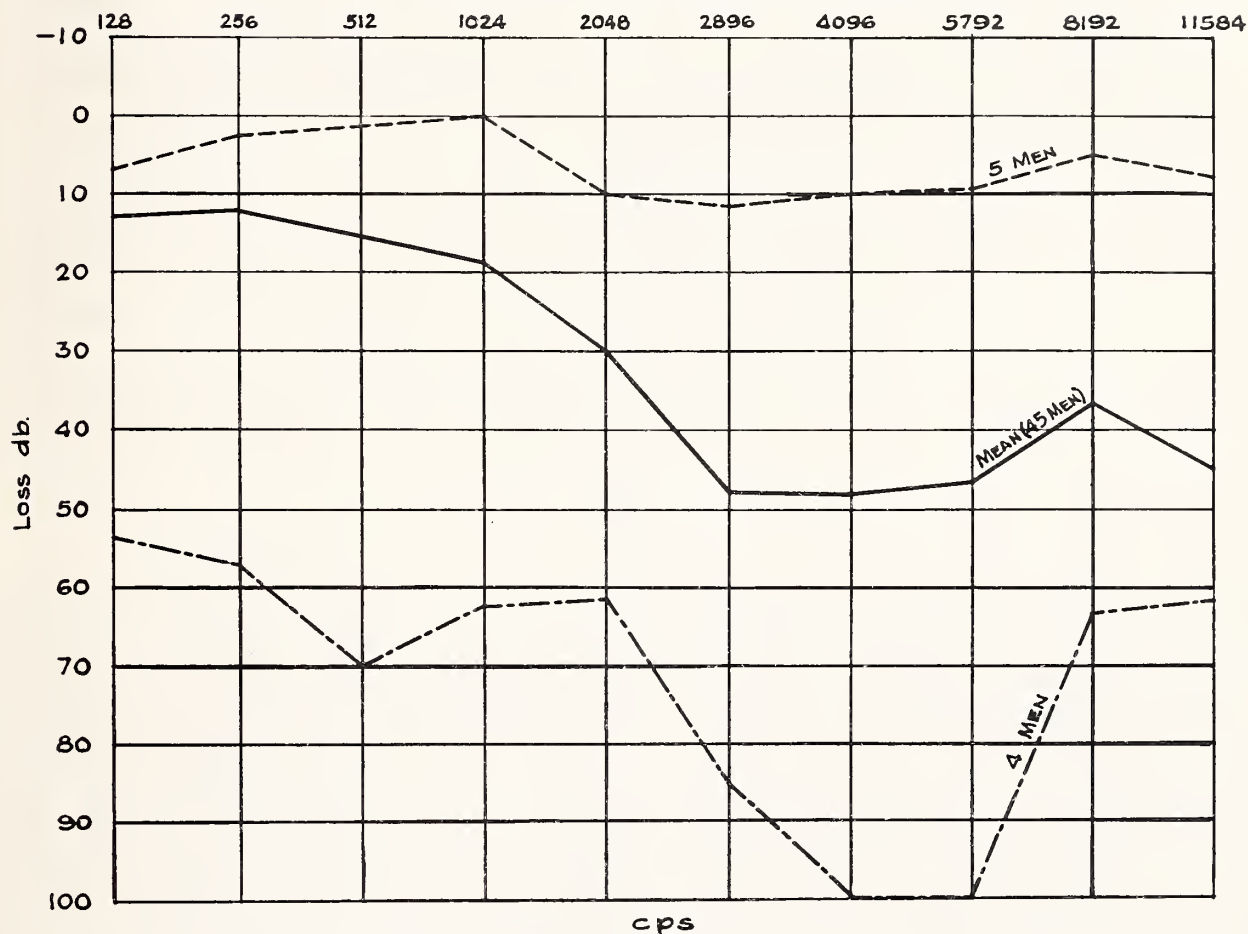


FIGURE 1

of causes of deafness as it occurs at random in the population. Among school children, for example, surveys have shown that from 5 to 7 per cent have measurable defects in hearing. Respiratory infections, pressure changes, and a multitude of factors apart from industrial exposure to noise, may enter into the production of deafness. An important consideration is the normal deterioration in hearing with age, into which additional variables of color, sex, etc., enter. Surveys by Bunch<sup>1</sup> and others have indicated that the mean magnitude of loss at 4096 and 5792 cps is of the general order of 5 to 10 db. for each decade after the third. It is possible to differentiate some of the cases of deafness as to cause, but often this cannot be done with certainty. Losses of hearing from steep-front pressure waves and sustained high noise levels, however, have similar and relatively constant characteristics which we can now examine.

## 2. CHARACTERISTICS

The general pattern of the hearing loss is shown in Figure 1. This mean audiogram was obtained by plotting at each frequency the means of the records of 45 men. One point of interest that emerges is that the points of maximum depression are distributed equally among three frequencies: 2896, 4096, and 5792 cps. This is true both in the case of the men who exhibited the least loss and those with the most severe losses. Studies on aural fatigue and recovery by Chamberlain<sup>2</sup> on boilermakers show the same general pattern. In Campbell's<sup>3</sup> systematic studies of fliers the first inflection of the normal curve appeared at 4096, but in his cases with more severe loss the adjacent frequencies of 2896 and 5792 were affected to an almost equal degree. Exposure of his men was to sustained high noise levels from aircraft engines, most of the fatiguing force lying under 1,000 cps. Bunch's<sup>4</sup> audiograms of trac-

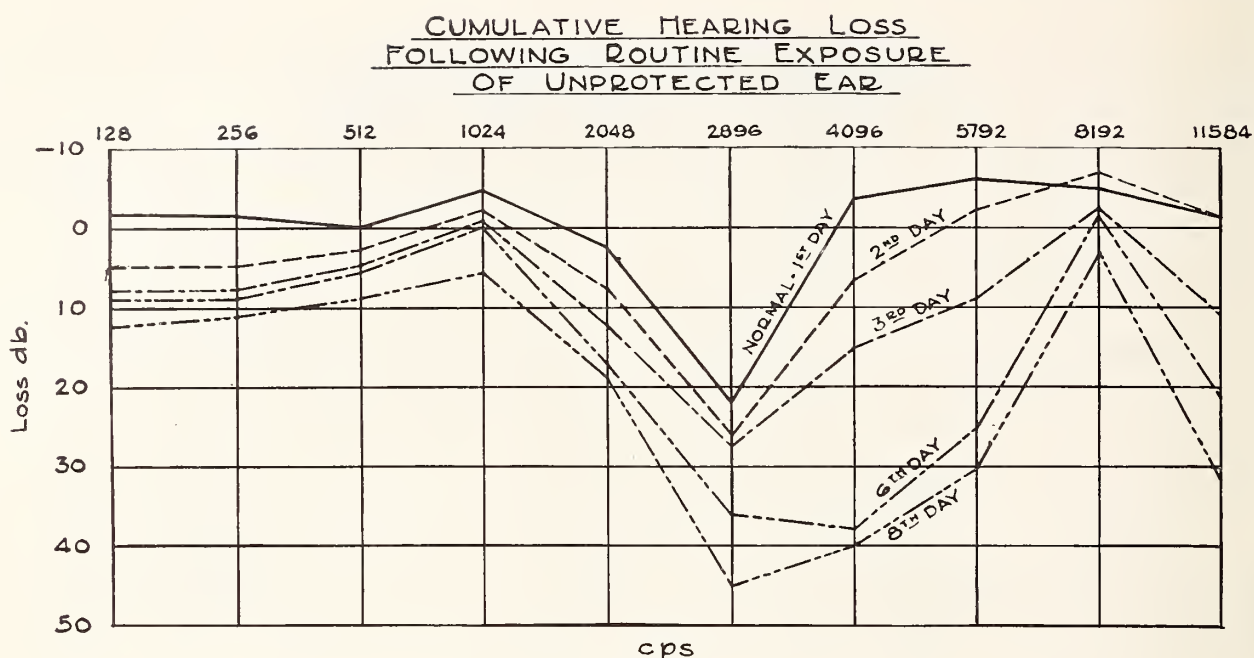


FIGURE 2

tor operators and a telephone operator showed similar points of maximum inflection. Rosenblith's<sup>5</sup> observations on boilermakers also led to the same pattern. Figure 1 illustrates another point of interest—namely, that in a group of 45 men great variability in amount of permanent injury resulted. This behavior is common to most biologic phenomena, whether the studies be made of fatigue, sensitivity to disease, and the like. In the case of occupational deafness, the differing order of effect may be related to measurable variables, such as orientation of the external meatus, shape of canal, etc., not yet clarified. Observed differences did not relate to duration of exposure.

The nature and course of the loss were studied under controlled conditions in a group of experimental subjects. An example of the mode of behavior may be seen in Figure 2. The initial pattern, which is like that described elsewhere, is most evident at one frequency. As insult is repeated, however, on successive days, the loss is cumulative. In general, the magnitude of exposures after the first was the same as that evident immediately after the initial injury.

Recovery from the trauma of high noise levels regularly occurs, and was of the order of from 10 to 40 db. on the first day of our studies (Figure 3). It can be seen that recovery is not complete even within four days after the last exposure, although the total magnitude of recovery is considerable in this time. It would appear that the temporary hear-

ing losses require long periods of time for recovery, and that the dips initially occurring are the prototypes of the permanent defects to come. Rosenblith,<sup>5</sup> in his studies, found 15 hours insufficient for recovery. Our own observations suggest that periods of days or weeks may be necessary. These results are like those of Campbell,<sup>3</sup> who found (among aviators) that recovery from small degrees of fatigue may be complete after periods of rest, but that constant repetition of the insult had a cumulative effect which resulted in permanent loss (in his studies the rest time approached the square of the time of operation of the fatiguing force). Permanent changes occurred in fliers, after as little as 250 hours of exposure.

### 3. PATHOLOGY

A number of studies since those of Wittmark and Popoff in 1929<sup>6</sup> have shown that destructive changes at the commencement of the basilar membrane in the organ of Corti with resultant changes in the neighboring ganglion cells will occur in experimental animals after prolonged exposure to high noise levels. Restudy of the problem by Davis<sup>7</sup> and others led to like findings. Severe and extensive damage occurred to the cochlea by loud tones without apparent injury to the eardrum, ossicles, or other apparatus. The least detectable anatomical difference, that is, the disappearance of mesothelial cells from a limited area of the lower surface of the basilar membrane, could be produced by frequencies of 1,000 cycles at a level of 140 db. for three



HEARING RECOVERY CHART  
AUDIOGRAMS FOR DAYS FOLLOWING  
LAST EXPOSURE

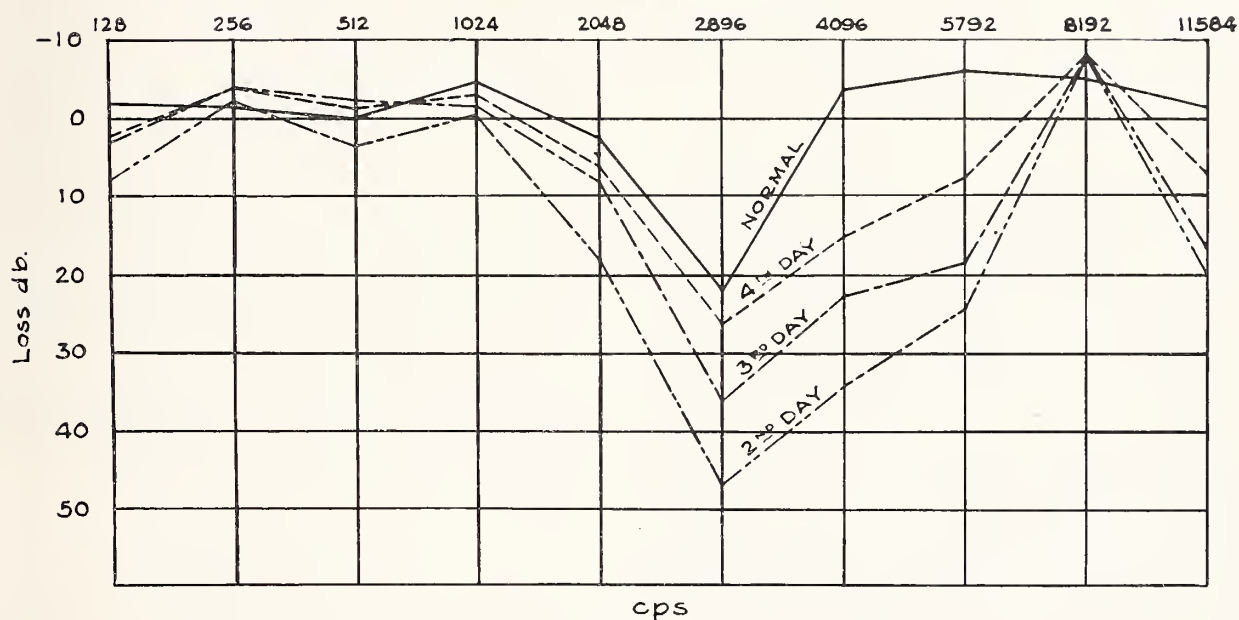


FIGURE 3

minutes. Consistent with clinical observations, milder degrees of damage were localized, but severe exposure caused widespread permanent damage.

#### 4. PREVENTION

Since high industrial noise levels are associated with deafness which may be permanent, and since animal experimentation has demonstrated pathologic changes in the organ of Corti, one naturally inquires as to what may be done by way of prevention. The obvious and direct attack is by reduction of noise level in the working environment. There is no reason for the continuance of general noise levels in certain industries at magnitudes which have been shown experimentally to produce loss of hearing. This will result in needless damage to an important sense organ. Numerous experiments and group undertakings have demonstrated increases in output and efficiency of workers when noise levels are reduced from troublesome to tolerable orders of magnitude; and we do not, indeed, require translation into decibels or cycles to tell us what our common experience has proven many times.

When one speaks of reduction of noise, it would be helpful to have some threshold or permissible level to which noise levels should be reduced. Regrettably, none is available. We do know that levels of 100 to 120 db. will produce fatigue and deafness, and that levels of 80 to 90 are annoying and troublesome. We do not have evidence that continued exposure to levels of the order of 80 to 90 db. for

long periods of time may lead to the acceleration of the normal deterioration in hearing which occurs with age.

With any impairment which shows such remarkable capacity for recovery with rest, rotation of personnel comes to mind. In view, however, of the likelihood of acquiring impairment by exposures of seconds or less, these requiring from four to six days for recovery, it becomes apparent that unless audiometry is regularly practiced in certain occupations, and there is opportunity for rotation in which men will be away from the high noise levels for periods of weeks or longer, that one cannot expect to accomplish much by this procedure.

Acoustic protective devices such as plugs, cotton, and the like, have been tried and are in frequent use. These have the disadvantages of attenuating hearing, requiring fitting, and cleansing, and do not, indeed, protect with a degree of effectiveness that is desirable in light of the nuisance entailed. Under certain circumstances acoustic protective devices may be the only means possible, but their limitations are considerable.

All studies on hearing loss from high noise levels have been consistent in the observation that great ranges of magnitude in susceptibility are evident in the groups. This immediately suggests the desirability of screening new employees for susceptibility. No works or reports on the application of this method have come to our attention, but it should

be tried as part of any systematic study of this problem in industry. We have seen gunnery instructors with years of exposure who have never used ear protection and who have normal hearing. Similar observations have been made on aviators and in the Lancashire cotton mills.

#### 5. NEEDS

The question of compensation for hearing loss in industry is becoming more important. Before 1938, the lack of uniformity in the methods employed for estimating the percentage of hearing loss for speech was astonishing and resulted in the formulation of a tentative method by the Consultants on Audiometers and Hearing Aids of the Council on Physical Medicine of the American Medical Association. Procedures were first described in the *Journal of the American Medical Association*, August 1, 1942. The work was reviewed and revised and reported again in the *Journal of the American Medical Association*, February 8, 1947. The new method is essentially unchanged from the tentative, and is simpler to use. We now have almost general agreement upon method for evaluation of hearing loss. Our problem, therefore, remains the relating of any existing losses to exposure in employment. The large number of variables make interpretation of isolated cases difficult, if not impossible. Too little is known about the importance of many variables, and we are all too often in the position of having no pre-employment, or repeated annual, audiograms on exposed workers. It would appear that the first step in any program should be the institution of pre-employment audiometric examination of all workers who are

likely to be exposed to high noise levels. Hand in hand with this, repeated surveys of the worst exposed groups is indicated, and study of the magnitude and spectrum of noise at various places in the occupation should be carried out. The problem is growing in importance. If we are to be faced with claims for compensation for loss of hearing, we require as a minimum, data on the capacities for hearing of the individual prior to employment and his course while employed. We need, moreover, to institute systematic studies of sound levels in the noisy industries; for the increment of injury contributed by the occupation can only be evaluated on large groups of men in relation to measured noise levels. Adequate, standardized instruments are commercially available, and the data waits to be gathered in industry.

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## OXIDIZED CELLULOSE IN NASAL AND PHARYNGEAL HEMORRHAGES

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SEVERE nasal hemorrhage has long been a problem of the general practitioner and rhinologist. Many of these fortunately cease spontaneously. Others can be controlled by pressure on the bleed-

ing area. However, there are some cases that are extremely annoying and cause anxiety to physician and patient alike.

Harvey<sup>1</sup> in his excellent monograph, covers the history of hemostasis in general surgery, including the use of styptics, cautery, clamp, and ligature. In more recent years newer methods have been ad-

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vanced such as the application of fibrinogen and thrombin, fibrin foam and thrombin,<sup>2</sup> gelatin sponge,<sup>3</sup> thrombin on soluble cellulose,<sup>4</sup> and the use of oxidized cellulose.<sup>5,6</sup> Much has been written of the clinical results obtained in surgery of the brain, liver, and prostate. Houser<sup>8</sup> has published a brief report on the advantages of oxidized cellulose in nasal bleeding. The latter material was used on the cases in this report.

Frantz<sup>5</sup> published the original work on oxidized cellulose in 1943, with later papers in 1945.<sup>6,7</sup> It was found that cellulose in any form, (cotton, gauze, paper) could be oxidized with nitrogen dioxide. Although the resultant product loses a certain amount of its tensile strength, this does not affect its use. It disintegrates in the autoclave, and hence must be sterilized by chemical means; it is supplied commercially in sterile packages. The original purpose of Frantz's research was to find a type of mechanical packing for hemostasis that could be left in situ without foreign body reaction. It was, therefore, a notable observation when it was realized that this material had especially applicable hemostatic properties of its own. It was further noted that unlike ordinary gauze, the cellulose expands on contact with fresh bleeding and turns black. It may be removed in forty-eight hours without sticking or may be left to be absorbed, with no ill effects.

This report covers a series of sixty cases in which oxidized gauze or cotton was used, fifty-seven of which were epistaxes, two were post-tonsillectomy hemorrhages, and one was post-operative bleeding following submucous removal of heavy bony exostoses from the maxilla in a case of Paget's disease of the facial bones.

All cases were first treated with one or more of the well known methods such as adrenalin packs, hydrogen peroxide, silver nitrate, actual cautery, submucosal injection of novocain-adrenalin or sodium morrhuate, vaseline gauze packing (anterior or posterior).<sup>9</sup> The oxidized gauze was used only on those cases failing to respond satisfactory to the above methods.

For comparison, we list the following cases:

I Epistaxis	
Hypertension .....	14
Trauma .....	4
Nasal fractures .....	3
U.R.I. with nasal congestion .....	7
Menstrual tension .....	3
Hemophilia .....	2
Purpura .....	2

Leukemia .....	2
Celiac Disease .....	1
Post-op. Submucous Resection .....	4
Mechanical obstruction due to deviated septum .....	4
Rheumatic Heart Disease .....	1
Congenital Heart Disease .....	1
Miscellaneous (varices, etc.) .....	9
II Post-tonsillectomy hemorrhage .....	2
III Paget's Disease .....	1

Two types of oxidized cellulose were used; gauze and cotton, and were applied directly to the bleeding area. The results may be divided into three groups. Complete and rapid cessation—fifty-two; rapid but temporary cessation—six; and failures—two. The first group was indeed gratifying. The second group comprised the six cases of blood dyscrasias and may be explained on the poor general condition of the patient due to that dyscrasia. The third group comprised the two post-operative tonsillectomy cases in which only the gauze was used. Because of poor accessibility to the bleeding areas in these adults and the lack of pliability of the gauze, the material could not be applied properly.

In four cases of group one, with posterior nasal bleeding, septal deviation caused severe nasal obstruction. Thus the bleeding area could not be seen and the material could not be easily applied. Two of these necessitated submucous resections of the bony septum before satisfactory arrest of the hemorrhage was obtained by application of oxidized gauge. The remaining two required only a somewhat larger amount of the gauge to control hemorrhage.

The advantages of this new hemostatic agent in otorhinolaryngology are worthy of recognition. In addition to its forementioned properties of hemostasis and absorbability, it is simply and easily applied, requires no addition of thrombin or other material, can be used in very small amounts, does not require pressure as ordinary gauze, and the results are achieved much more rapidly than with other methods.

The only disadvantage is a minor one. If fresh blood is on the instrument used in the application of the cellulose, it will stick to the instrument rather than to the bleeding area. Obviously, this difficulty is easily overcome.

SUMMARY

In fifty-eight cases of nasal and two cases of post-tonsillectomy hemorrhage, oxidized cellulose was used to stop the bleeding. Ease of application and

prompt action are advantages which render this hemostatic agent preferable to other methods.

#### ACKNOWLEDGMENT

The oxidized cellulose was supplied by Johnson & Johnson, New Brunswick, N. J., under the trade name of HEMO-PAK, Hemostatic Absorbable Gauze and Cotton.

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## TERATOMA OF THE MEDIASTINUM — A CASE REPORT

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**M**EDIASTINAL tumors are always a challenge to diagnosis because a multitude of diseases give similar signs, symptoms and x-ray findings. Dermoid cysts and the related teratomas are an uncommon type of tumor. Because of the unusual complete past history and follow up, this case is being presented.

At the age of twenty-nine years while going through the Army Separation Center, this soldier was found to have a mass in the mediastinum and was admitted to an Army hospital.

Chief complaints: Sensation of pinching and squeezes along left chest wall.

Family history: Father died at forty-six years of heart disease. Mother l. & w., 4 brothers l. & w., one died of pulm. t.b.c. at the age of twenty-five years.

Past history: Uncontributory. Venereal history: negative.

Occupational history: Tank driver 1942-1945; Engine assembly man in factory prior to entry into the Army. No exposure to industrial gases or dust. No duty outside Europe or U. S. A.

Present illness: Entered the service in 1942 in good physical condition. (See Figure 1.) He gave a history that during the Battle of the Bulge (Dec. 1944) his tank was hit by enemy fire and he was thrown against the side of the tank. He believed he might have been unconscious for a minute or two and when he regained consciousness he was unable to determine accurately whether he had been injured. He was not hospitalized nor did he receive any medical attention, continued combat. Three months before

admission he thought that he developed a cold with a vague pain in the left chest. He was treated by the battalion surgeon with cough medicine. There was a pinching sensation in the left chest along the axillary fold and especially when lying on the left side. While in the hospital he noted that during walking he felt a throbbing and pulsating sensation in the left neck vessels and in the left axilla. No pains or aches. No respiratory complaints. Appetite was good. After climbing long or steep steps or walking for half a mile or more he noticed a pounding of the heart for 3-4 minutes.

Physical examination: Height 5'6½". Weight 162. T, R, P normal. Skin Head-Neck: normal. Lungs: Clear to percussion and auscultation except for dullness and decreased fremitus in the left suprasternal cardiac area. Heart and vessels: No enlargement noted, dullness over left upper heart border. Apex inside fifth interspace. Greatest cardiac impulse noted in the third left i. sp. P<sub>2</sub> greater than A<sub>2</sub> with loud rushing sound, but murmur not definite. Rate and rhythm normal. Left carotid and axillary arterial pulsation seem greater than those on the right. Pulse 80. BP 110/68 rt arm, 118/65 lt arm. Abdomen and musculoskeletal system, neurological exam: neg. Pupils: normal reactions. Urine: neg. Kahn: neg. Wasserman: neg. RBC 5.4 mill. WBC 7200. Polys: 62 per cent with 6 stab cells. Lymphos: 32 per cent. Findings showed no change on repeat examination. Consultation noted by cardiologist: BP right arm 130/80, left arm 125/80. No heart murmurs. Impaired percussion in the left infraclavicular area. EKG negative. Rate 77. P-R interval 0.16 sec., normal sinus rhythm.

X-ray of chest reveals a bulging of the superior mediastinum to the left at the level between D<sub>5</sub>-D<sub>9</sub>. The density was sharply defined and was located in the anterior mediastinum. On fluoroscopy the tumor showed expansile pulsation, becoming larger on ventricular systole and smaller on deep inspiration. X-ray diagnosis: Aneurysm of pulmon-



ary artery. This diagnosis was accepted by the internist and cardiologist and patient discharged from the hospital. (See figure 2.)

In June 1946 he was seen at the VA Regional Office Clinic in the course of routine periodic re-examinations. The tumor was again observed and noted that it had grown to about twice its size. He gave a history that he was able to carry on light work and that he was helping with the work in a small plant of his brother. (See figure 3.) He was re-examined five months later and again it was noted that the tumor has expanded in size. He also stated that several days ago while carrying a case of about forty pounds he suddenly had precordial pain and syncope. He also had a similar episode while driving his car. Because of the rapid increase in the size of the tumor and its location in the anterior chest, the validity of his discharge diagnosis was questioned and he was referred to Vet. Hospital in Newington. (See figure 4.) There extensive studies in cooperation with the New Haven Hospital x-ray department were carried out. Laminography, angiography and kymograms were performed. The findings were not conclusive. However angiography showed failure of filling of the mass and it was felt that the mass was extracardiac. EKG readings were consistently negative. Therefore a diagnosis of a mediastinal tumor was considered and operation advised. He refused surgery but two months later he returned with aggravation of dyspnoea.

X-rays revealed bulging of the superior mediastinum to the left between the level of D5-D9 with outer border of the tumor reaching the anterior axillary line. All laboratory tests were repeated, showed no change. Vital capacity was 3.1 and 3.8 liters compared with an average normal of 4.5 liters. On March 27, 1947 an operation was performed. Endotracheal anesthesia was employed. On opening of the chest a large cystic mass measured 10" by 7" was found, lying close to the left anterior border of the heart extending up to the aortic arch. Posteriorly it nestled between the left border of heart and the left lower lobe of the lung, which was moderately compressed and somewhat atelectatic. The cyst was very thin walled and bits of cholesterol could be seen through the wall. Patient went through the procedure well and immediately postoperatively felt comfortable. (Figure 5.) The specimen showed on gross and microscopic examination the following (abbreviated report):

The cyst has been opened and contains about 225 cc of reddish, cloudy fluid in which there are many greenish granules of soft soap-like material. As the cyst lies collapsed, closed and flat, it measures 14 cm. in diameter and the thickness from 2 cm. over one-half to 2 mm. over the other half. The external surface shows over one-half the area a roughened appearance indicating the area of separation from adjoining tissue. Loose tags of fibrous and fatty tissue are attached. The other half of the surface is covered with a smooth, serous surface with a few fibrous tags attached. The inner lining generally shows a smooth serous surface. Cystic nodules project into the lumen; one is 1 cm. diameter, with a tenacious mucus inside. Section of the prominence shows a multilocular cystic structure, with variable-sized cysts.

Microscopic: Multiple sections from various portions of the mass show a diverse picture of multiple tissues character-

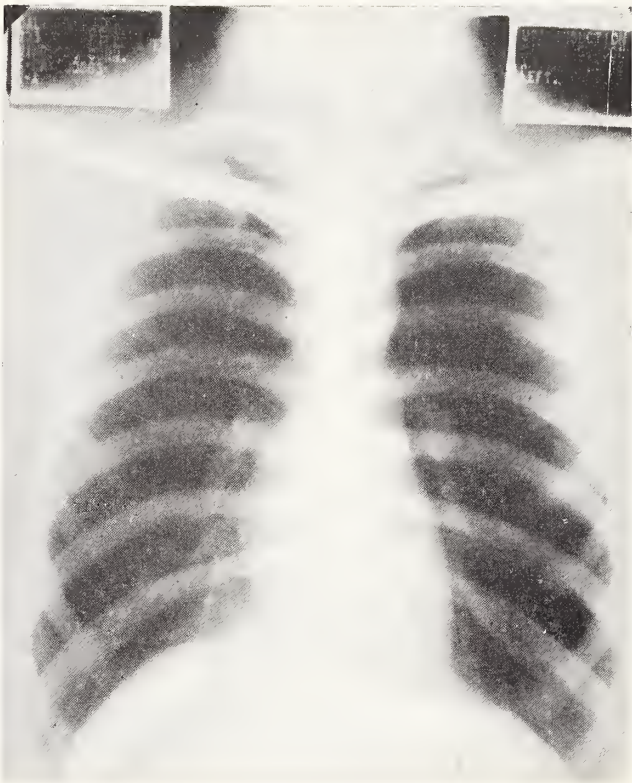


FIGURE 1  
Film taken at Induction

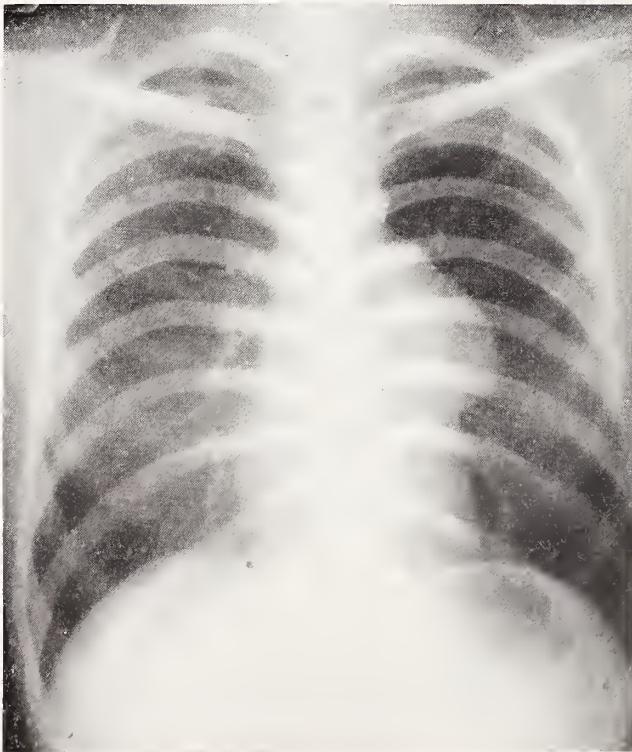


FIGURE 2  
Film taken at Discharge



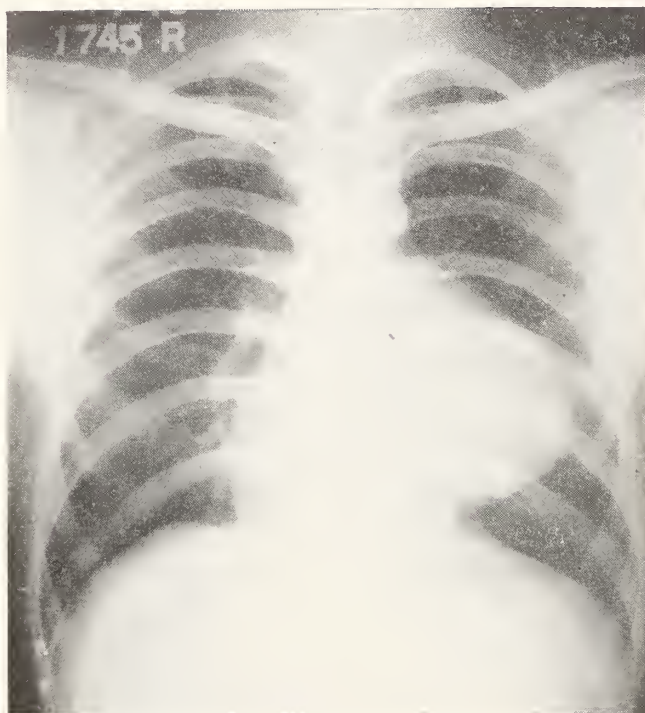


FIGURE 3  
PA View



FIGURE 3  
Left lateral view

istic of teratoma. There are various cysts, some of which are lined by a thin layer of stratified squamous epithelium, and filled with desquamated keratin; others are lined by flattened to tall columnar epithelium of a mucus secreting type. In one area, the glandular epithelium is tall columnar in type and the stroma contains numerous small dark cells overlying whorls of smooth muscle. In some areas the cyst lining is transitional from glandular to transitional epithelium. The cyst wall varies from myxomatous to fibrous in type and contains a few small foci of calcification and a number of hair shafts. Diagnosis, teratoma, mediastinum.

#### DISCUSSION

Dermoid cysts and teratoma are rare tumors and until 1939 only 245 well authenticated cases were described. In the Army tumor registry there are twenty-nine cases recorded. Sixteen of these were carefully reviewed by Schlumberger in 1946. Among 746 admissions to the Brooklyn Naval Hospital, special chest tumor center, there is only one case on record.

**Pathology:** The tumor is embryonic in type may remain dormant until adolescence or adult life. Active growth may occur at any age group. Occasionally they are incidental post mortem findings. There is no sex preference. Suddenly they may show active and rapid growth. Most cases in the literature mention a cold or pneumonia at onset of rapid growth, although this is open to question. Trauma as suggested by the above history is not stressed and was presumably absent in nearly all cases on record.

**Anatomy:** Anterior mediastinum usually have a pedicle to the center of the chest and extend into the right or left chest. Neither side is favored. They usually hug the anterior pericardium, aorta and hilum. Usually adherent to pericardium, chest wall, pleura or large vessels.

**Histology:** There is the simple dermoid cyst with its predominant ectodermal elements, containing structures of skin, sebaceous glands, hair follicles, sweat glands or tooth formation, but it may show elements of all three germinal layers. There is a gradual bridging toward the solid teratoma usually consisting of cell structures of all embryonic layers.

**Symptoms and signs:** Cough, dyspnoea, suffocating attacks, pain, anginal attacks with pain in the right or left hand, engorgement of the neck vessels. Palpitation. Horner syndrome and voice changes have but rarely been described.

#### COMPLICATIONS

1. Progressive increase in size and mechanical obstruction.
2. Development of bronchial fistula.
3. Rupture into the aorta, pericardium and pleura, empyema, bronchiectasis and secondary pulmonary



infection. These may be the cause for sudden death.

4. Development of adhesions.

5. Malignant change. This occurs in about 10 per cent of all cases. In the cases reviewed by Schlumberger there were 10 benign tumors and 6 malignant tumors, so manifested by appearance of pulmonary metastases.

#### PHYSICAL EXAMINATION

May be entirely negative. Sputum may contain sebaceous material in cases of bronchial fistulae, or hair or cholesterol crystals but the latter are distinctive but not pathognomonic. Aspiration is contraindicated because an aneurysm may represent the underlying pathology with fatal consequences.

X-ray examinations are helpful, because it localizes the tumor to the anterior mediastinum. A pedicle to the center of the chest may be visualized. The surface is smooth in case of a dermoid cyst and may be lobulated in case of a teratoma. Teeth may be seen, but this is rare, pulmonary calcification or vessels may simulate teeth-like structures. Fluid levels may be encountered in cases of bronchial fistulae. Some authors believe that the aqueous and fatty matter of the cyst may separate into layers and show fluid levels. Kymograms are usually of little help, there is always some transmitted pulsation and most aneurysms show no pulsations.

Laminography is of limited value.

Angiography may be very helpful and suggest the diagnosis.

Bronchography may be diagnostic in cases of fistulae.

Thoracoscopy can be applied, however exploratory chest surgery is preferred.

Asheim-Zondek test may be helpful in cases of teratoma if they contain chorionepithelioma-like elements. Most cases in the literature reported neg. A-Z tests. But there are singular cases on record with a pos. A-Z test with exclusion of testicular tumors and pregnancy.

#### DIFFERENTIAL DIAGNOSIS

1. Thymoma—a highly malignant tumor.
2. Lymphosarcoma—both are radiosensitive tumors.
3. Aneurysm of aorta or pulmonary artery. Syphilis may be present in a case of dermoid cyst and pulsation in aneurysm is more frequently absent than present.
4. Lipoma.
5. Bronchogenic carcinoma.
6. Mediastinal cysts of gastric or bronchial origin.
7. Pericardial cysts.
8. Pulmonary cysts.

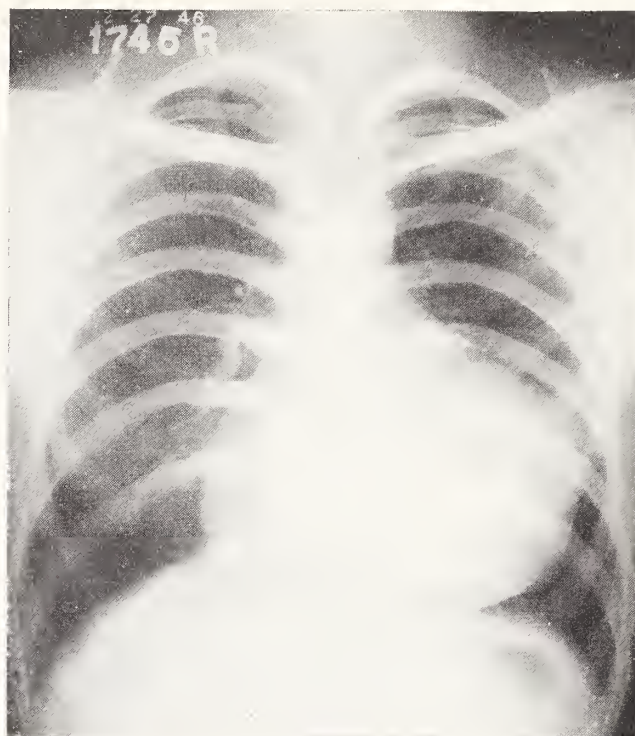


FIGURE 4  
PA View

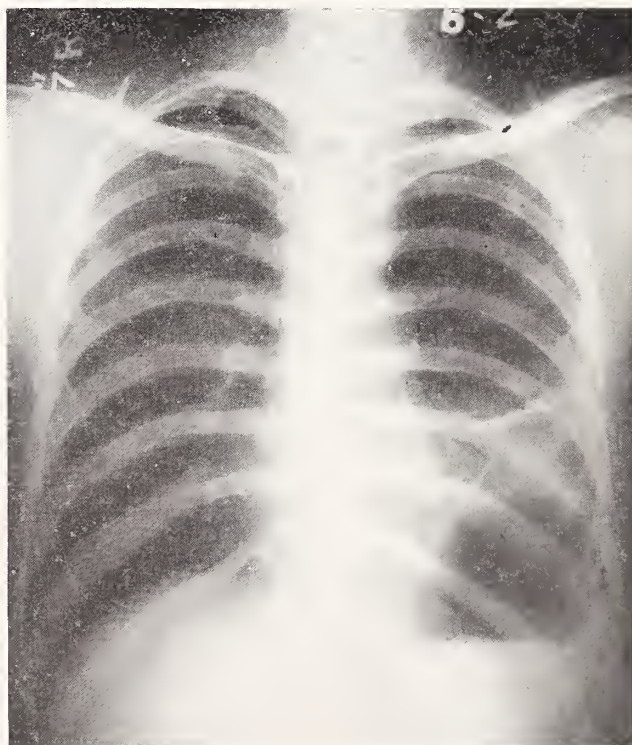


FIGURE 5  
Postoperative film

9. Echinococcus cysts: Complement fixation tests and skin tests are diagnostic.

10. Mediastinal goiter.

#### TREATMENT

Surgical removal. Only about 5 per cent of all tumors were accidentally uncovered by post mortem examination and did not contribute to the cause of death. In a study of forty cases where the tumor caused death there was an average life span of 1.8 years between the onset of symptoms and death. In some there was a history of symptoms of many years' duration and in some the fatal outcome followed several weeks after onset of symptoms.

Surgical mortality is low and varies with the skill of the surgeon and surgical team. The mortality rate is at present probably somewhere between 1 and 3 per cent.

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## PSYCHIATRY AND THE FUTURE OF MEDICINE

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THERE have been several periods in the history of medicine when a technical innovation caused a revolution, which affected hospital organization, medical education, and the lives of doctors as practitioners. This happened when the techniques of the autopsy and of pathology came into the picture. It happened with the advent of modern bacteriology and epidemiology. It happened with the introduction of modern chemistry. It is happening now with the development of electronics; and it will be my thesis that we are watching the start of a similar revolution today because of the subtle influence of psychiatry, and particularly of dynamic psychoanalytic psychiatry on our whole culture and specifically on the medical sciences.

When a revolution is coming one can do one of two things: either wait to ride it out hoping for the best, or swim out to meet the wave, hoping to ride it in more securely, or, if I abandon my metaphor, perhaps even to guide it into constructive channels. At any rate this is my rationalization for attempting these few prophecies.

Underlying what I am saying is the assumption

that the technique of psychoanalysis and the body of theory which has developed through it constitute a technical innovation which has led to the uncovering of vast new areas of human thought and experience. I could spend the rest of this afternoon, and indeed many an afternoon, arguing the pros and cons of this assumption. However, this would not be very profitable. Let me ask you instead to accept the assumption as a working hypothesis.

The most important significance of analysis is not merely its therapeutic use. Indeed I would remind you that in the 1926 edition of the *Encyclopedia Britannica*, Freud himself wrote that ultimately analysis would not be thought of primarily as a therapeutic technique, but rather as a systematic concept of human nature. This is because analysis has placed in our hands a microscope which gives us an opportunity to see all layers of human nature. The neurotic components of normal humanity are thus brought into view for the first time. As a therapeutic method psychoanalysis is faulty, and it undoubtedly will be profoundly changed in the course of the next twenty-five years. But as an instrument for the dissection and study of human personality its influence has already been incalculable.

Thirty-five years ago there were few physicians practicing community psychiatry as we think of it today. In this country less than twenty-five people



called themselves analysts at that time, and most of those did not have any right to the name. Today there are nearly four hundred accredited analysts. In the New York Psychoanalytic Institute alone there are 125 members, and about 110 students at present, with 150 more trying to get in next year. When we consider how few analysts there were throughout the world forty years ago, one is impressed at how small a group this was to exercise so great an influence on the development of human culture. The increasing emphasis on the study not merely of the psychosis or even of the outspoken neurosis, but rather on the study of normal personality, has taken psychiatry out of the mental hospital, and has made of it a tool with which we attack many of the basic problems of human life: e.g., the problems of family life, and domestic relationships, the development of children, adjustments in school at every level from kindergarten through graduate work in colleges, in courts, and in social agencies. It has become part of the air we breathe, to such an extent that we have almost ceased to realize how great an innovation in human culture this means. The most important part of this development is the fact that human discontent, our age-old conundrum, is no longer looked upon as a problem in morals, nor as something to tackle with exhortation, the arts, religion, or with flight into play. It has become instead a major world-wide public health problem.

Thus the neurotic component of human nature is now recognized as a universal disease; and has become the central concern of any mental health program. It is obvious then that psychiatry reaches into so many areas that it can no longer remain the exclusive concern of the medical profession. Physicians will play a leading role in research on methods of prevention, therapy and diagnosis. Ultimately it will also be our job to help to develop methods of education by which others can be trained in practical applications of psychiatric knowledge.

The experience of the war is so widely known that I hardly need to spend more than a moment reviewing the statistical evidence for the universality of the problem of human neurosis. It is unquestionably the greatest health problem in the world, statistically outweighing all others. Optimistic statements, such as the recent statement of Dr. Burlingame, are mere efforts to persuade us to bury our heads in sand. The problem does not cease to exist when we close our eyes. More beds are devoted to the mentally sick than to all other diseases com-

bined. Over 600,000 beds for mental patients and another 600,000 patients who are either out on parole or in remissions. Yet this is the smaller part of the problem. Surgeon General Parran recently pointed out that one in ten members of our population seek psychiatric help at some time in their lives. The estimate as to the incidence of the frank neuroses varies from 6 to 12 millions in a population of 140,000,000. In order to put fifteen million men into uniform we had to exclude and discharge 1,750,000 for neuropsychiatric disabilities, the majority of whom were for neuroses. Actually there were even more than that; because many neuroses were able to carry on in the services in spite of, and sometimes even because of their neuroses. Keen general practitioners and consultants in internal medicine estimate that between 60 and 70 per cent of their daily practice is primarily a problem of the neurosis. Experience with the use of psychiatry on the wards of a general hospital bear this out. When a psychiatric unit starts to work on a hospital ward, it begins with 2 to 3 per cent of the patients on the ward. Before it has been there six months, however, 60 to 70 per cent of the population of the ward are referred to it; and, I may add, many of the young doctors and nurses as well. (Kubie.<sup>1</sup>) Everywhere lurks this need, which becomes an insistent, pressing and articulate demand as soon as we offer any psychiatric help at all. If we offer nothing then everyone pretends that the need does not exist.

In all of this there is nothing which is new. We have not created a world of neurotics. We have merely recognized as an illness the forces which have made human beings unhappy for many generations. We have recognized that from infancy on every human being lives a life which is suspended between two groups of internal psychological forces, some leading to healthy, flexible adjustments, and some leading to the masked and subtle forms of neurotic disability. This is human lot, because we do not yet know enough about how human infants should develop. Therefore the struggle goes on in everyone, accounting for much of the tension and emotional vulnerability with which we live. It is because of this incessant internal struggle that many of the homely proverbs about human nature are naive expressions of fundamental truths: such as the saying that we do not learn from experience, or that we succeed only to have success turn to dust and ashes, etc. These are simple, homely acknowledgments of the effects of concealed neurotic forces in

the human living which we euphemistically call "normal," which is the best that most of us ever achieve. If this is the situation which we face, if even in health we struggle with a process of illness which is universal and widespread, we must approach it differently from the way in which we approach such relatively rare illnesses as neurological disorders. The problems of selection, of training, and of preparation of personnel, and the integration of the specialist with the community as a whole, become entirely different; and as physicians we must recognize this difference. Otherwise, we will miss the full implications of these elementary facts.

It would be very comfortable if we could solve this problem by preventing the illnesses; and certainly this should be our ultimate goal. But here we are caught in a well known vicious circle. We cannot bring up healthy children unless we have healthy parents; and it is hard to be a healthy parent if we have gone through the curiously masked torment which constitutes the childhood of most human childhoods. When we know more about how to bring up children we may be able to reduce some of the neurotic forces which distort our development; but we cannot wait on the solution of the problem of prevention to reduce the magnitude of the present need. The only prevention which is available to us today to any significant extent is the prevention which results from early treatment.

However, here again we are up against a bad tradition. It is traditional in medicine to diagnose neuroses by exclusion, and to treat them only as a last resort. This is destructive and wasteful. Neuroses can be diagnosed on positive evidence, without the exclusion of concomitant organic illness. One can have measles and a broken leg. One can have a physical injury and hysteria. The physician of tomorrow must be keen enough to detect and recognize the co-existence of the two. If one proceeds always in the traditional fashion, considering at first only the organic possibilities, and undertaking the treatment of the neurotic component only after organic medicine has blunted its tools against the neurosis, then the psychiatrist usually finds himself up against a patient who is permanently spoiled for psychiatric treatment. That is an experience which every psychiatrist faces in his practice constantly. Furthermore, to make an early psychiatric evaluation of every patient is important for another reason. If this is done routinely with every patient, no stigma is attached; whereas if we single

out special patients for psychiatric study, they feel as though the finger of scorn has been pointed at them, and therefore resist it bitterly.

Even more important is the effect of the organic mill on the average patient. I wonder how many of us have attempted to treat psychiatric patients after they have been through eight or ten years of repeated, complicated, highly skilled organic investigations, all of which in the end have turned out negative. I think of a patient of mine who had been through eleven flawless gastro-intestinal series, all the time having nothing wrong with his gastro-intestinal tract. What does this do to a man? What does even one, or two such experiences do? When a patient goes through the misery and discomfort of these impressive and melodramatic organic procedures, he tends to come out with the conviction, "There must be something wrong with me, otherwise the doctors would never have put me through all of that." Frequently one can make little dent in that conviction. Experience goes deeper than words; and there is many a patient who has been made inaccessible to treatment by the premature introduction of conscientious but unnecessary organic investigations; unnecessary, that is, had one followed the elementary rule of medicine, which is first to take a careful history. It would be an interesting experiment for the out-patient department of any hospital to take a statistically adequate random sample of all patients (excepting of course the emergencies) and to route them through a psychiatric screen *before* doing anything else at all, in order to see how much would be saved in terms of patients' time, doctors' time, laboratory technicians' time, laboratory equipment, and the endless stream of repeaters who go from one clinic to another, or who come back to the same hospital for years. The records of the repeaters in any hospital represent a tremendous waste of medical skill; and a high proportion of these are patients who were recognized as neurotic at the first examination, but with no attention given to the neurosis until years had gone by in fruitless organic procedures. Against these I have serious objections when they are used before a patient has been emotionally and psychologically prepared to accept the procedures without psychic injury.

What I am saying implies that we must revamp our approach to the patient by introducing adequate psychiatric appraisal of every human being as early as we check his blood pressure, or his urine, or his



blood picture, or listen to his heart, or lungs, or look in his throat. If this confronted every patient immediately, whether in the private office or in the hospital it would constitute a screening process, to route the patient through his subsequent examinations. This would also mean that psychotherapy would have to be made available even for patients who have organic disease. When a patient with an organic illness also has a disturbed personality, his response to treatment will be influenced by his psychological problem. Therefore in such cases we have the double obligation to treat his body and at the same time to treat his emotional utilization of organic illness. I must emphasize again the fact that everyone can utilize organic disease for neurotic purposes, exactly as does a classical hysteria. This is why the model patient in the Army hospital so often becomes the headache of the Veterans Administration. Organic illness can provide the same escape that the hysterical symptom does for the hysterical patient. This again is why they are so often overlooked on the general wards. While sick, they are relatively contented; and because they make no trouble on the ward, doctors and nurses often make the mistake of thinking of them as stoical and cheerful and non-neurotic. We still think of the neurotic as somebody who is jumping up and down, acting in some queer hysterical fashion, whereas in reality there is a vast number in whom the effect of the neurosis itself is to protect them from any such disturbing emotional displays. It is precisely here that the adequacy of the training of the physician is measured by his ability to recognize the subtle manifestations of masked emotional difficulties, whether these are masked by neurotic symptoms or by organic symptoms.

Implicit in all that I am saying is the necessity for creating a closer partnership between psychiatry and internal medicine, between psychiatry and surgery, between psychiatry and the specialties, than has ever existed, a partnership both in the private office and in the hospital. It means, further, that our responsibility is to treat every outbreak of manifest neurotic difficulties as acute medical emergencies. We will then treat the onset of any acute neurotic disturbance, whether in a child or in an adult, as though it were an acute appendix, and requiring just as immediate attention. In other words, we will apply to civilian practice the lesson learned in the war, namely that if we treat these disturbances early we can accomplish a great deal in a relatively short

time. This cannot always be done of course; because sometimes an acute emergency is the manifestation of a deeper underlying process. Nevertheless an extraordinary percentage of these cases if treated at once can be helped in a relatively short time; whereas if help is delayed the neurotic process gells rapidly, and becomes chronic. In this connection I always think of two women who had neuroses as nearly identical as is possible for any neuroses to be. Their symptoms were identical. Because of a strange coincidence, the pattern of their lives, their ages, and the sex relationships among their children, the kind of human beings the parents were, all were at least as much alike as two human faces. One of these young women was brought to me by her physician within two months of the outbreak of severe neurotic difficulties. When he came he said to me, "I've talked to her: I've given her some sedation; I've tried to see what reassurance and common sense and advice and scolding and rest and a vacation can do. Obviously they are not going to touch this thing. Now I am going to clear out of the picture so as not to interfere with you. Will you hit it fast." The other physician is an internist who prides himself on his psychiatric approach, and on how much "psychotherapy" he can give to his patients himself. He had given his patient his personal variety of psychotherapy for nearly twelve years. The first woman was 24; the second 34. It took eight months of analytical work to cure the first: and nearly six years to cure the second patient of an identical illness. This is a situation which confronts us constantly in our dealings with our colleagues and with our patients. Patients usually reach the psychiatrist only years after the onset of an illness which should have been treated within the first weeks.

In this sense, as I said before, early treatment merges with prevention; because if one treats early enough, particularly in childhood, one prevents the accumulation of residual neurotic scars out of which our adult neuroses and our adult neurotic difficulties are built.

What I have said will also indicate that I do not believe that much adequate psychotherapy can be given by the general practitioner, the internist, or the surgeon. Under the banner of psychosomatic medicine it is popular these days to say that a great deal of psychotherapy can be taken care of by these men. This seems to me to be unrealistic wishful thinking. I too wish it were possible, because then our whole problem would be simpler; but for sev-

eral reasons I am afraid that it cannot be. In the first place, it is difficult for one man to play both roles with any patient. I am still a neurologist. Nonetheless I early learned that it was not a wise thing for me to play the role of neurologist and analytic psychiatrist with the same patient. In the second place, the average internist and surgeon, as we all know, is under terrific pressure. Many medical patients require a great deal of unpredictable time. Psychotherapy requires a slow and patient routine, and cannot be pushed rapidly. Words which are helpful and illuminating if said slowly, patiently, and spaced out over days, become destructive if hurried. With the pressure under which the internist and surgeon works he cannot give that amount of time, because he does not have it. With the best will in the world it is impossible. Many men in military service have said to me afterwards that the one thing that haunted their consciences was how they had upset patients by pushing facts at them before the patients were ready for them, because of limitations of time.

The other error that the general man or the internist or surgeon is likely to make is to gloss things over. If he is astute he can frequently aid a patient temporarily to rid himself of certain symptoms; but to "cure" a symptom in this superficial way often merely obscures a disease process; and the disease process then goes on to break out in more serious forms years later. Instead of using the initial symptoms as a warning signal, as an opportunity to attack the roots of the problem when it is young and fresh, superficial therapy is frequently used to hide the underlying process. Then when the patient finally reaches the psychiatrist, we face a life that has been strained out of shape by a battle with a neurotic process that has gone on for years. Obviously this creates a much tougher therapeutic situation.

How, then, are we going to meet this challenge which has become articulate. Can our medical schools train enough medical students to become psychiatrists to meet this need? Here again I have to be pessimistic, and point to the perilous state of medical education in the country today. As Alan Gregg and others have pointed out, our medical schools face shrinking budgets and rising operating costs. In the face of the upward spiral in the cost of living, salaries have remained practically stationary, with the result that a dangerously large number of medical educators are being drained out of medical education and research in order to earn a living;

and not enough new young men are coming into the field. Furthermore, we are not increasing the number of our medical schools. Actually the situation is quite the reverse. In 1900 when we had a population of 76,000,000, we had 28,000 medical students. In 1910, after the cleaning out of the poor medical schools, our medical student population had dropped to 13,000. In 1920 it was 14,000. In 1930 it was up to 21,000. In 1940, with a population of 132,000,000, we still had less medical students than we had in 1900—i.e., only 25,000. So we have not even caught up to ourselves. We all know of the difficult time that able young graduates from colleges are having getting into medical school. There are not enough medical schools, or places for medical students. Consequently it is all that our medical schools can do to supply the country with internists and surgeons.

In psychiatry we are even worse off. There are 4,011 members of the American Psychiatric Association. About 3,200 of those work full time in mental hospitals, leaving less than a thousand to take care of all community needs. It is a conservative estimate that we need between 8,000 and 10,000 in our mental hospitals alone, and that we need between 20,000 and 30,000 in the communities. As General Menninger recently pointed out, when he surveyed the training facilities of the entire country he discovered that we turn out somewhere between 50 and 75 psychiatrists a year. This is just about enough to take care of the annual loss from death, old age, illness, and retirement; so that we are just a little better than keeping up with ourselves.

So as not to omit any of the gloom from the picture, we should remember that training psychiatrists is the longest apprenticeship in medicine, with the possible exception of brain surgery. After medical school come a couple of years of general internship, then at least two years of psychiatric internship, then three or four years of special training in psychotherapy. Today in the case of all young men who train in our major centers, this means training in psychoanalytic psychotherapy. Of the last hundred physicians their average age on admission as students in the New York Psychoanalytic Institute was 34 years and six months; nearly 39 years when they graduated. Consider what that means. We are a healthy group when we start out to be doctors; but as Dr. Dublin has recently pointed out, "after the age of 50 our life expectancy drops below that of the rest of the population. We burn ourselves out



rapidly. Consequently a man may study for 40 years in order to have only 15 to 25 years in which to use the skills he has acquired for the benefit of the community, and also to earn security for his old age and an education of his children. Both from the community's point of view, and from the individual point of view, this does not make sense.

There are many reasons why time is necessary in the training of the psychiatrist. In the first place, you cannot make psychiatrists out of emotional adolescents. It takes maturity which must be based on life experience. Physicians who want to become psychiatrists must be people who are ready to face some of life's responsibilities, such as a family and children, and who thereby know something of what life and its problems are about. Consequently we cannot start training young people to be psychiatrists.

In the second place, and this is a point that is completely overlooked in the selection of teaching personnel for medical schools, clinical maturity comes slowly in psychiatry. Compared to any other specialty, the psychiatrist can see relatively few patients at a time. This is not true in that early phase of hospital training which one receives in a clearing house hospital, such as Bellevue or the Boston Psychopathic. But the psychiatry of the future is the psychiatry of the neurosis; and whereas a house officer in internal medicine or in surgery can in three or four years see a vast number of patients on the hospital wards, in the psychiatry of the neuroses it takes ten or fifteen years to achieve a comparable clinical maturity.

Nevertheless, somehow or other we must bring into medicine and the community as a whole a group of people who are adequately trained to meet the challenge of psychological medicine, the challenge of psychotherapy. If we cannot achieve this by turning all of our internists and surgeons into psychotherapists, and if our medical schools are seriously handicapped in training even enough internists and surgeons, and if our training facilities in psychiatry are as inadequate as they are today, what then can we do about it? My own conviction is that we need a new profession, a paramedical specialty, a doctorate in medical psychology, trained in our medical schools and teaching hospitals, trained therefore in the atmosphere of therapeutic responsibility and of therapeutic self-critique of our

best medical traditions. In this the medical education would have to be pruned of a great deal that is superfluous. For instance, instead of devoting a thousand hours to teaching anatomy, as most medical schools do, we will make use of modern visual aids and teach the anatomy which a doctor in medical psychology would need in one hundred hours. A great deal of such pruning could be done all along the line; and the Doctor of Medical Psychology would be graduated from medical school in four to five years after receiving his M.A. in psychology. This should be compared to the ten to twelve years required to train a medical psychiatrist for adequate work with the neurosis. (Cf. Frankwood Williams;<sup>4</sup> Kubie.<sup>3</sup>)

This brings me back to where I started. There is no solution to this problem unless we work out a partnership between the man who is dealing with the psychological problems of neuroses and the man who is dealing with the organic problems of organic medicine: two parallel disciplines, two types of physicians. Both would be physicians, both trained in the traditions and institutions of American medicine: one whose major focus would be on organic, bodily ailments, and the other on emotional and neurotic disturbances. It seems to me that their mutual influence on one another could hardly fail to be good, both in practice and in the atmosphere of medical education. In fact, we might then achieve the goal which Stanley Cobb described some years ago, namely a medicine which is built like a tripod to stand on three legs—medicine, surgery, and psychiatry. In time this might also develop enough people to bring into our whole culture the kind of understanding of human personality which at present is omitted almost wholly from our educational processes.

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## EDITORIALS

### More Nurses

The present recruitment campaign which has assumed nationwide proportions is producing results and our training schools are again filling up their depleted numbers. Nevertheless, the supply of student nurses and nurses is still far less than the demand. The present need for more nurses is primarily due to greatly increased hospital occupancy and the demands for nursing service in allied fields. Neither of these demands will lessen in the future, and both will expand. In consideration of the present shortage of nurses some have suggested that a shorter training period and less educational requirements might do much to remedy the situation. It is not likely that this would be so and furthermore as physicians who readily recognize the professional nursing responsibilities, we should hesitate to endorse any compromise with the necessity for the continued maintenance of adequate professional standards for nurses. For its final solution the problem of nurse shortage can only be met by an increased desire on the part of young women for enrollment in our training schools.

The part that the individual physician can and should play in furthering the program for nurse recruitment is a very important one. In considering, therefore, the opportunities for young women in this field, which is an integral part of modern medicine, he should be aware of important changes which are taking place in training schools, changes involving increased social and recreational oppor-

tunities, and financial assistance when needed. Furthermore, he should realize that training in a modern training school is equivalent to a college education and in the long view such training has beneficial effects in producing good wives and mothers, and a better citizenry. The committee of the American Medical Association studying the nursing problem is giving considerable attention to the economic and security questions.

A share in the recruitment of student nurses therefore belongs on the doctor's doorstep. He is often in a strategic position to give aid and advice to young women who are contemplating the future. In so doing he is directly helping a great cause, and incidentally, himself.

### Some Generalizations On Specialization

In a recent article in the *Saturday Evening Post*, Dr. Mary B. Spahr states that in the past fifteen years the percentage of medical specialists has risen from twenty-five to fifty. Here is food for thought, perhaps for action? Should we, as physicians, attempt to influence this development, or should we adopt a laissez-faire attitude? It might well be that attempts to change the course of events would be mere quixotic tilting against windmills or comparable to King Canute's attempt to stem the tide. In any event, no harm can be done by considering some of the factors which underlie the situation.

The practice of medicine is based partly on science and partly on art and, as Francis Peabody



pointed out, the science of medicine and the art of medicine can, and should be, complementary. In the past there have been myopic or prejudiced individuals who regarded medical science and medical art as antagonistic. Within the memory of many of us there were practitioners who regarded laboratory specialists as impractical dreamers and laboratory workers who regarded many practitioners as unscientific, rule-of-thumb artisans. But this period has passed, and in recent years there has been a tendency to overstress the value of laboratory and technical tests at the expense of simple clinical procedures such as careful history taking and adequate physical and psychic examinations. The wise physician tries to visualize the patient as a whole by correlating these different types of data.

Specialization per se is not a modern development. One need only peruse the Hippocratic oath, with its reference to those who "cut for the stone," or delve into the records of ancient Egyptian medicine, to realize that it is an old, old story. It is true that the number of specialties has greatly increased in the past fifty years, and that this expansion markedly accelerated during the present century. In the main this was a matter of necessity, for many of the newer sciences, such as bacteriology and immunology, and those split off the older disciplines, as pharmacology and physiological chemistry, were detached from physiology, developed techniques and enlarged in scope to an extent that demanded all the working energy of their devotees. The growth of new clinical specialties, often only possible through advances in the science of medicine, has usually been due to the pioneering of masters in new fields, for example the development of neuro-surgery by Harvey Cushing and Victor Horsley. In part too specialization has been a matter of choice plus special aptitude and unusual opportunity. Thus, one might fairly claim that plastic surgery has attained its present prominence as a result of the great wars of the present century with their mutilating techniques. Nor must we neglect to take account of urbanization, undoubtedly one factor in the spread of specialization, especially since the advent of newer and more rapid means of transportation has decreased the isolation of districts formerly remote from large cities.

Specialism, like most human activities, has both advantages and drawbacks. From the purely professional standpoint its chief advantage lies in the fact that constant repetition increases skill: diagnostic,

prognostic, and therapeutic. The man who is daily dealing with a limited group of diseases becomes more expert than the man who encounters them only occasionally. The chief disadvantage of specialization is that it tends to engender a restricted and often biased outlook. This danger is greatest when the specialist has not had a wide preliminary training in general medicine and surgery, which is now much less common than formerly when specialists commonly developed from general practitioners. The specialist tends to find evidences of disease in his particular field in every patient who consults him, and runs the risk of overlooking other, and sometimes more important, aspects of the case.

There are doubtless considerations other than purely professional ones, which lead many physicians to embrace a specialty. The work is often more easy to organize, the working period is more rigidly controllable, and the fees, per unit of time, are higher than those received by the family doctor. To be sure, these statements are not equally true of all specialties. A dermatologist is not nearly so likely to be hauled out of bed as an obstetrician or a surgeon, and the factor of responsibility for life and death, with the resultant strain, is much greater in some specialties than in others. As a matter of fact some specialists, notably busy obstetricians, lead a more onerous life than most general practitioners.

What all this adds up to is this: shall we attempt to discourage the growth of specialism on the ground that it is eliminating the family doctor, or shall we recognize that further development of specialism is inevitable but that its practice needs more rigorous regulation? As to the first query, it would seem that new discoveries in medicine are bound to occur and certain to result in increasing specialization, the history of the past half century obviously supporting this view. Stricter regulation of specialization is another story. At present State Examining Boards license physicians to practice medicine and surgery and permit them to practice any specialty without enquiring into the adequacy of their special training. It is true that representatives of the important specialties have set up their own Examining Boards, formulated their own rules as to training, and issue certificates of competency to those who successfully pass their tests. But this procedure is independent of State licensing laws and does not prevent practitioners who may be inadequately trained from proclaiming themselves specialists. There is no question that the activities of these

special boards have definitely raised the standards of competence in the specialties, but there are still too many self styled specialists who fail to develop a satisfactory degree of competence in their field. There is no reason why state laws should not be amended so that licensing boards would demand of specialists evidences of competency, and this could be done by allowing them to accredit the diplomas of the Specialist Boards just as many of them now accept those of the National Board of Examiners.

And what of the General Practitioner? Must he, like the Dodo and the Great Auk, undergo extinction? We hope not. There are plenty of statistics available which demonstrate that the majority of diseases for which patients consult physicians are comparatively simple, many of minor severity, and usually not difficult to treat. Not that the situation is quite the same as it was at the beginning of the century. Many of the infections have been all but wiped out in civilized communities, though to keep some of them in check preventive inoculations of one kind or another are necessary. Some new diseases have appeared, but few of them seem likely to become as widespread as our old enemies smallpox, typhoid fever and diphtheria. The percentage of old people in the population, now usually referred to under the pleasant euphemism of "the elderly," has greatly increased, and will continue to do so. For this reason further research into the degenerative diseases is essential. It is likewise a fact that there is still great need for education of adults in the necessity for periodic check-ups. While, therefore, the work of the general practitioner has been somewhat modified, there are still many things that he is as well or better fitted to do than a specialist, and it is sincerely to be hoped that he will not disappear or even persist as a mere middleman or jobber. There is no reason to believe that he will not, as in the past, refer to specialists such patients as may need their care.

G. B.

### A Problem of Age

The change that is taking place in age groups in the nation's population is of great social significance. Modern methods of disease control and prevention have increased the average length of life of the American people to exceed 65 years according to statistics compiled by the Metropolitan Insurance Company. The political significance of such

change will be seen when individuals over sixty actually hold the balance of voting power. Some time ago Mark Sullivan stated that by 1965 some 40,000,000 people in our nation will have to support 116,000,000. In considering this statement, Dr. Edward L. Bortz, president of the American Medical Association, makes this analysis: "Certain other data are important. For discussion purposes one may divide the population into three groups—the young, the old, and those of working age. The present population of the nation is around 140,000,000. Twenty-five years from now it will be approximately 160,000,000. While this is not a spectacular increase in the total population, it is expected that the number of elderly folks will reach approximately 20,000,000. On the other hand, with a decline in the birth rate, if such continues, in 25 years from now, those under 20 will be somewhat over 60,000,000. This would leave, if one deducts those over 65 and those under 20, approximately 80,000,000 who will have to support the entire population. But if half of this solid group is made up of housewives and others who aren't wage-earners, then probably 40,000,000 workers will support a total of 160,000,000. The social and cultural changes inherent in such a transformation of the population age groups will be reflected in broad developments for the security of those individuals who are reaching the upper age brackets."

Social security for people over 60 years of age is already a major problem but in its consideration it is essential that the thinking include factors other than those of financial aspect. It is of equal importance for this enlarging consumer group that the productive capacity of the individual should be considered. "This is the crux of the aging problem," says the writer just quoted, "to find useful employment for the elderly to give their later years significance and to maintain them as contributing members of the body politic." Professor Ralph Barton Perry of Harvard states that it is high time for an Age Movement as well as a Youth Movement in our social economy.

The question arises naturally, when is a man old? The inflexible rules of retirement now existent in many of our universities and industrial organizations should be surveyed with a view to the establishment of some other system than that based on calendar maturity. It is interesting to consider what the world might have lost by the application of such rules to the creative genius of Titian, Michael



Angelo, Franklin, Victor Hugo and Tolstoy, and in our own time to Edison, Toscanini, Cordell Hull, Stimson, and Justice Holmes, to mention a few from a list which could be continued a hundred-fold.

More than anything else today the world needs the counsel of men with mature minds, men with long experience in dealing with the perplexities of mankind.

## England Offers a Solution to the Nursing Shortage

The Working Party of the British Government recently issued a report on the Recruitment and Training of Nurses. This is the first time the Working Party has provided evidence on the point that there are enough women of the degree of intelligence to implement the program of the educational policy of the Nursing Councils. This program calls for an elevation in the academic status of nursing in order to provide nurses with an understanding of the theory of what they do. The syllabus includes anatomy, physiology, and theoretical medicine and resembles that laid down for medical students. It is believed that any lowering of this standard will keep potential nurses out of the profession.

The remedy for the present shortage is a shorter and necessarily simpler, but at the same time more comprehensive training. It suggests that time could be saved by the elimination of domestic work and unnecessary repetition, and by more efficient training. The interesting factor in the report is the suggestion that Nurse Training Units be set up independent of individual hospitals and responsible for coordinating all the educational facilities in the region for the benefit of the student nurse. The suggested replacement of the assistant nurse by a nursing orderly is an integral part of the scheme. The *British Medical Journal*, commenting on this proposal, says that "the disappearance of the individual hospital as a training unit would mean the immediate loss of a sense of loyalty which it would be difficult for a Nurse Training Unit to re-create. But there is no progress without risks, and if these proposals are to be put into practice the new educational bodies will need the courage and vision to inspire something like the spirit of university."

Perhaps the Working Party in England has something worth considering by the medical and nursing professions of the United States.

## Television in the Operating Room

The surgeons at Johns Hopkins apparently are convinced that the use of television is the best method to be employed in the clinical instruction of surgery to a group of more than three or four people. If this is true operating rooms being constructed today without allowance for the use of television already are outmoded. Not only is it difficult for more than two or three people to see the operative field in the average operating room, but it is a well established fact that the number of pathogenic organisms which may be cultured from an operating room is in direct proportion to the number of people in the room, in spite of caps, gowns and masks.

On February 27, 1947 television of surgical operations was used for the first time at the Johns Hopkins Hospital. Two television cameras were in constant use during the experiment. Five operations were recorded and so sharp were the images reproduced that when a dollar bill was placed on the operating table for the purpose of focusing the estimated distance of the operating field from the camera, the serial numbers on the bill could be read clearly on the projection screens. The pictures were registered in black and white since technicolor is still in its experimental stage in television.

Recently the American College of Surgeons at its regional meeting in New York City reproduced certain operative procedures to the group assembled in the Waldorf Astoria hotel.

Again medicine progresses by utilizing modern science.

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## Connecticut Journal Placed First

At the recent Secretaries-Editors Conference in Chicago the CONNECTICUT STATE MEDICAL JOURNAL was accorded first place in typographic distinction by the chief engineer of Waverly Press who is also associate professor of industrial engineering at Johns Hopkins University. Mr. Roy characterized the JOURNAL as "most legible and most attractive."

The other journals studied were those from the California, Ohio, and Wisconsin State Medical Societies. These three together with the Connecticut JOURNAL had previously been selected by a committee as the four outstanding state medical society publications.

## THE PRESIDENT'S PAGE

One of the prices that must be paid for freedom is self discipline. Without discipline a crowd becomes a mob. The need for discipline is greater as the population becomes more dense and as society becomes more complicated. Since the needs of society are eventually answered in one way or another, it follows that strong police action is likely to develop where self discipline is lacking.

This truth holds for groups as well as for individuals. Physicians are one such group. Some have wondered if the organized profession is aware of its responsibility, is willing to assume it and is capable of keeping its house in order.

As an organized profession we have group obligations in connection with providing medical care for the veterans, and we are offering the public a voluntary prepaid insurance program. Both of these undertakings call for considerable self discipline. We cannot tolerate participation in these programs by any physician who allows avarice to get the better of his finer sensibilities. The leaders of the profession are aware of this responsibility and have faith that the profession is anxious and able to keep its house in order.

J. R. Miller



FROM THE SECRETARY'S OFFICE

CREIGHTON BARKER, M.D.

GRACE MOONEY, PH.D.

258 CHURCH STREET      NEW HAVEN

The regular monthly meeting of the Council was called to order by the Chairman, Dr. Murdock, on Monday, November 3 at 4:00 P. M. at the offices of the Society. There were present: Drs. Murdock, Thoms, Speight, Gildersleeve, LaMoure, Parmelee, Miller, Gibson, Burlingame, Weld, Weed, Harvey, Howard, Barker, Miss Mooney. Dr. Thomas J. Danaher, Secretary of the Litchfield County Medical Association, was present as a guest. Absent: Dr. Phillips.

The Council noted with deep regret the death of Dr. Charles C. Gildersleeve, 81, of Norwich, formerly a President of the Society.

BUDGET FOR 1948

The budget for 1948 which had been prepared by the Budget Committee was presented and analyzed by Dr. Cole B. Gibson, Treasurer, and was approved by the Council for recommendation to the House of Delegates.

It was voted to recommend to the House of Delegates that membership dues be continued at twenty dollars.

BUILDING FUND APPOINTMENT

The appointment of Dr. Stuart H. Bowman, Stamford, to succeed Dr. Raymond A. Gandy as a member of the Board of Trustees of the Building Fund was approved.

COMMITTEE ON NUTRITION

Dr. James R. Miller, Hartford, Dr. David Gaberman, Hartford, and Dr. Max Caplan, Meriden, who had been appointed as delegates to the State Nutritional Council were named to constitute a Committee on Nutrition for the Society. Dr. Miller will serve as Chairman of the Committee.

STUDY OF MEDICAL EXAMINER SYSTEM

In compliance with the request of the Association of Medical Examiners that the Society appoint a committee to study the medical examiner's system in Connecticut, the following committee was appointed: Brae Rafferty, Willimantic, Chairman; John D. Booth, Danbury; George H. Gildersleeve, Norwich; Marvin M. Scarbrough, New Haven; Walter Weissenborn, Hartford. The Committee is to report to the Council and House of Delegates at an appropriate time.

CANCER DETECTION CENTERS

The Secretary presented a progress report for the Council's special committee to establish standards for cancer detection clinics. The committee consists of Chairman, Dr. Bliss B. Clark, New Britain, Dr. John B. Ogilvie, Stamford, and Dr. Max Taffel, New Haven.

PREPAID MEDICAL SERVICE

Dr. Miller presented the report of the Committee on Prepaid Medical Service which is to be given to the House of Delegates at its Semi-Annual Meeting on December 4. The Council approved its presentation. Additional discussion was entered into concerning the prepaid surgical and obstetrical insurance plan which has been developed.

DISTINGUISHED SERVICE MEDAL

Dr. Weed, the Councilor from Litchfield County, proposed that the Council nominate Dr. W. Bradford Walker of Cornwall, as a candidate to receive the Distinguished Service Medal for General Practitioners which is to be awarded by the American Medical Association. Dr. Weed's proposal was accepted by the Council and the Secretary forwarded the nomination by telegram to the Secretary of the American Medical Association.

VETERANS MEDICAL CARE PLAN

There was extensive discussion of the operation of the "Home-Town Medical Care Plan for Veterans" and the Council voted that the Secretary communicate with the Chief Medical Officer of the Veterans Administration informing him that the Council of the State Medical Society stood ready

at all times to investigate cases of alleged abuse and exploitation of the Veterans Administration's Medical Care Plan on the part of members of the Society.

### Meetings Held During November

Monday, November 3, 4:00 P. M.

Council of the Society

Monday, November 10, 5:00 P. M.

Committee on Cooperation with the Yale School of Medicine

Wednesday, November 12, 10:00 A. M.

Written examinations of the Connecticut Medical Examining Board, State Capitol, Hartford

Thursday, November 13, 10:00 A. M.

Written examinations of the Connecticut Medical Examining Board

3:00 P. M.

Committee on Public Health

Committee on Tumor Study, Brady Memorial Laboratory

4:00 P. M.

Association of Connecticut Tumor Clinics, New Haven Hospital

Tuesday, November 18, 4:30 P. M.

Committee on Rural Medical Service

Wednesday, November 19, 1:30 P. M.

Committee on Industrial Health, Pratt-Whitney Aircraft Division, United Aircraft Corporation, East Hartford

4:00 P. M.

Committee on Maternal Mortality and Morbidity

Thursday, November 20, 4:30 P. M.

Committee on Military History

Committee to Study the Workmen's Compensation Laws, Graduates Club

Wednesday, November 26

Executive meeting of the Connecticut Medical Examining Board

### Meetings Scheduled for December

Thursday, December 4, 3:30 P. M.

Semi-annual meeting of the House of Delegates, New Haven Medical Association

7:00 P. M.

Mid-Winter Dinner of the Society and the Woman's Auxiliary, New Haven Lawn Club

Friday, December 19, 4:00 P. M.

Council of the Society

Meetings are held at the offices of the Society unless otherwise indicated.

### Recent Clinical Congress

The Twenty-Second Annual Connecticut Clinical Congress held at Yale University and the New Haven Hospital on September 16, 17 and 18, was attended by more than 700 Connecticut physicians.

The Congress proved significant this year because of its wide range of medical subjects, the number of leaders in medicine who addressed the gathering, and the success of the afternoon panel discussions.

The adequate facilities provided by the planning committee enabled the Congress to function efficiently during all three days of the program. The morning sessions were held in the auditorium of the Yale University Law School and the afternoon panel discussions and demonstrations at the New Haven Hospital.

The press this year paid more attention to the Congress than at any previous time, and representatives from several Connecticut newspapers and the Associated Press attended most of the morning sessions. Good attendance was experienced at all of the panel discussions, and it is considered probable that many who did not register for the morning sessions attended these meetings of the Congress.

## THESE GAVE

### CONTRIBUTORS TO THE BUILDING FUND, OCTOBER 10 TO NOVEMBER 10

#### FAIRFIELD COUNTY

Gibson, D. F., Danbury  
Hansell, R. J., Greenwich  
Stankard, W. F., Stamford  
Ward, J. P., Bridgeport  
Yasser, I., Bridgeport

#### HARTFORD COUNTY

Denne, T. H., West Hartford  
DePasquale, J. A., Hartford  
DeVito, M. J., Hartford  
Giorgio, N. A., Hartford  
Kalin, J. I., Hartford

#### HARTFORD COUNTY—Cont.

Keefe, W. J., Hartford  
Marranzini, S., Hartford  
McLean, J. J., Hartford  
Scafarello, P. J., Hartford  
White, E. P., Hartford



## Dr. Harvey Appointed to New Post



SAMUEL C. HARVEY, M.D.

Dr. Samuel C. Harvey has been appointed to head a newly organized Department of Oncology at the Yale University School of Medicine.

Announcement of the new department and the appointment of Dr. Harvey was made recently by Dean C. N. Hugh Long, who stated that the action is intended to centralize all of the medical school's research activities in cancer.

As head of the department, Dr. Harvey becomes Yale's first Professor of Surgery with special reference to oncology. He will assume responsibility for furthering Yale's extensive research program in cancer, and for the training of medical students and physicians in cancer diagnosis and treatment. To accept the new post, he recently retired from the William H. Carmalt Professorship of Surgery and as chairman of the medical school's Department of Surgery.

A member of the Yale faculty since 1917, Dr. Harvey is president elect of the Connecticut State Medical Society, and has been surgeon in chief at the New Haven Hospital. He received his medical

degree at Yale University School of Medicine in 1911, and an honorary degree from Western Reserve University in 1931.

The new chair in surgery is supported by grants from the National Cancer Institute of the United States Public Health Service, and Robert S. Hunter, Class of 19118, Pasadena, California. The Connecticut Cancer Society has established a generous grant to aid in the operation of the university's cancer detection clinic.

In announcing the appointment, Dean Long declared that "Interest in cancer research and therapy at Yale has been increasing over the past few years, and this centralization of activity under Dr. Harvey promises a coordinated attack on many fronts.

"The tumor clinic was set up in 1928, the Atypical Growth Research Unit in 1932, and the Tumor Registry in 1936, which is closely affiliated with the Central Registry in the Connecticut State Department of Health for recording and following all cases of cancer seen in the clinics of the New Haven Hospital.

"Yale is now headquarters for one of the largest funds for investigating cancer, the Jane Coffin Childs Fund for the Study of Cancer, which amounts to several million dollars, and sponsors research throughout the nation. Grants from this source and from other agencies have served to activate extensive and important research in the pre-clinical departments of science in the School of Medicine.

"Early this year a Detection Clinic for the routine examination of any persons fearful of having cancer was set up in connection with the Tumor Clinic and Registry under the auspices of the Connecticut Cancer Society. It has become apparent that if responsibility were centered in one individual—like Dr. Harvey—activities in the field of cancer would be stimulated and more closely associated. Equally important is the ability to attract promising young physicians to work in this field so they would become concerned with cancer in man, and would be informed as to advances made in the laboratories at Yale and elsewhere.

"This professorship in the field of oncology should place Yale well in the fore in the investigation of cancer and the application of the newest information to persons suffering from the disease."

## AMERICAN ACADEMY OF PEDIATRICS, CONNECTICUT BRANCH

## Progress Report National Study of Child Health Services in Connecticut, Sept. 30, 1947

J. HAROLD ROOT, M.D., *Chairman*

AGENCIES, organizations and individuals who are awaiting "findings" of the "Pediatric Survey" will be cheered to hear that all material is now on its way toward final tabulation. This includes all schedules which were returned by pediatricians, physicians and dentists in private practice, hospitals, both general and special, nursing homes, and public health agencies of all types supplying any kind of health service for children.

Filling out questionnaires is a tedious and time-consuming job but of extreme importance in this instance as it was the only way information could be gathered simultaneously in so many different areas and representing the only information ever gathered in some of these particular areas.

The Academy and Survey Staff are grateful for the assistance and cooperation given the project by all pediatricians, physicians, dentists, nurses, health officers and the many different people in hospitals, clinics and all of the health agencies including the boards of education who gave of their time and personal knowledge in local areas and situations. This has been extremely helpful in the attempt to show the facts as accurately as possible.

The following returns were received from total number of questionnaires sent out in the areas of medical care for children:

Pediatricians in private practice 95 per cent (Total questionnaires sent out 134).

Physicians in private practice 85 per cent (Total questionnaires sent out 2431).

Dentists in private practice 80 per cent (Total questionnaires sent out 1370).

Securing reliable data for the part of the survey dealing with health services available was a difficult task due in part to the multiplicity and various types of health services available at both state and local level, and the added complexity of the many local health jurisdictions in addition to the lack of uniformity in keeping records. The latter makes for confusion in attempting to make evaluations or comparisons.

At the time that the survey was set up, there were 190 health jurisdictions consisting of 13 full time health jurisdictions and 13 full time health

officers; also 177 part time health jurisdictions and 140 part time health officers including those in towns, cities and boroughs.

Another area presenting difficulties is the lack of breakdown in statistical records regarding child care in hospitals. While most hospitals in the State acknowledge giving care to child patients, whether they may or may not have specific facilities for children, many do not keep records pertaining to type, volume and extent of such service to child patients. It is therefore difficult to get an accurate total picture.

A total of 104 survey forms were used in Connecticut hospitals and nursing homes giving care to children. Only hospitals giving care to children were included as eligible hospitals.

47 were surveyed for general information as general, maternity or pediatric hospitals.

37 of the above were surveyed particularly for facilities for care of child patients and newborns.

7 hospitals and nursing homes classified as convalescent hospitals or nursing homes.

5 hospitals were surveyed as either separate hospitals for communicable diseases or general hospitals having isolation units of 10 or more beds.

4 classified as nervous and mental hospitals.

3 classified as specialized tuberculosis hospitals or units.

1 orthopedic hospital.

There was a 100 per cent return on these questionnaires!

A special committee has been appointed representing the Medical Society, the Dental Society, The American Academy of Pediatrics, and public health services with consultants from other areas to be called in as needed. This committee will analyze the findings, indicate recommendations and assist with the preparation of the final report on this Study in Connecticut, which is to be published within the year.

At the request of the Connecticut Conference of Social Work, The American Academy of Pediatrics presented a panel discussion on the Preliminary Report on the National Study of Child Health



Services in Connecticut on November 13 in Waterbury.

The Connecticut Branch of the American Academy of Pediatrics takes this opportunity to express its thanks and appreciation of the Academy and Survey Staff to all physicians and dentists who returned their individual, completed questionnaires; and also wishes to acknowledge the help of all administrators and staff members in all hospitals and nursing homes, public health agencies, both private and official, and superintendents of schools, who completed questionnaires on the various aspects of this really tremendous study.

### Academy of General Practice Planned

Plans for the organization of a Connecticut chapter of the American Academy of General Practice have been announced following a meeting held recently in Middletown.

The announcement was made by Henry Sherwood and Julius H. Grower, both of Middletown, who were appointed national delegates for the Academy in Connecticut at the centennial meeting of the American Medical Association in Atlantic City last June.

In a letter concerning the meeting held in Middletown on November 1, the following physicians are named as county delegates: Fairfield County, David L. Ellrich, 125 East State Street, Westport; Hartford County, William F. Storms, 147 Main Street, Wethersfield; Litchfield County, C. Norton Warner, Jr., Litchfield; Middlesex County, A. Benjamin Rafkind, 108 Main Street, Middletown; New Haven County, Walter V. Corey, 1188 Whitney Avenue, Hamden; New London County, Harold A. Bergendahl, 63 Broadway, Norwich; Tolland County, Francis H. Burke, 45 Park Street, Rockville; Windham County, William Mac Shepard, 66 Main Street, Putnam.

Present plans call for the formal organization of the Connecticut chapter at a meeting to be held in New Haven sometime in January.

Charter members will be those physicians who are accepted for membership prior to January, 1948. It is explained that a membership requirement of 150 hours of postgraduate medical study will be waived for charter members who will be permitted to complete this requirement during their first three year period of membership. After January 1, 1948, evidence of postgraduate study will become

a pre-membership requirement. Memberships shall terminate at the end of three years, and to be eligible for re-election a member must have spent a minimum of 150 hours in postgraduate training.

Although no list has yet been published concerning the type of training to be embodied in this requirement, Dr. Grower states that it is at present indicated that the plan will follow somewhat those of similar local groups who have allowed about one third of the hours at staff meetings, one third at conventions, and one third for enrollment in postgraduate courses.

To be eligible for membership physicians must be engaged in general medical practice and must have completed at least three years of such practice. Special consideration will be given in cases of military medical service, it is stated. Also, applicants must have had at least one year of rotating internship at an approved hospital, or the equivalent in postgraduate training. Though the Academy has no direct connection with the American Medical Association, membership in the AMA will be required of all applicants, according to the announcement.

The American Academy of General Practice was founded on June 10, 1947. According to its constitution, the objects and purposes of the Academy are as follows:

1. To promote and maintain high standards of the general practice of medicine and surgery;
2. To encourage and assist young men and women in preparing, qualifying, and establishing themselves in general practice;
3. To protect the right of the General Practitioner to engage in medical and surgical procedures for which he is qualified by training and experience;
4. To assist in providing postgraduate study courses for General Practitioners, and to encourage and assist practicing physicians and surgeons in participating in such training;
5. To advance medical science and private and public health.

### Renews Interest in Cosmetics

The Council on Pharmacy and Chemistry of the AMA, renewing its interest in the field of cosmetics, is now actively building a file on the subject to meet inquiries of physicians and their patients. The file will include among other things the causes of reactions that occur following the use of some cosmetics.

## SECRETARIES-EDITORS CONFERENCE—CHICAGO, NOVEMBER 7 AND 8

The privilege afforded each year by the American Medical Association to the secretaries and editors of the various State Medical Associations for a pooling of ideas and an attempt at a solution of common problems continues to be appreciated. This was again attested to this year by the large attendance of physicians from every State in the Union. It reflects credit on the parent organization in that it has seen fit to continue this custom for over thirty years, through the periods of two wars. Several fundamental problems of either State society secretaries or editors were discussed at the recent conference. Prepaid medical care plans, public relations, relations with labor, federal and state legislation, rural medicine, State society conventions, the coordinating of State society activities with the AMA, the medical journal, and the World Medical Association were all approached by the common method of speaker and questions or by panel discussions.

## SEEING IS BELIEVING AND RELIEVING

Bruno Gebhard, M.D., director of the Cleveland Health Museum, presented graphically the best methods of preparing and displaying exhibits for lay groups. Not content with the advantage of a platform, he bounced down the aisle disdaining the idea (if anyone had such a thought) of being a stuffed shirt and proceeded to call for a show of hands of all present who were certified. Back on the platform again he made an interesting observation that in the physician's contact with his patient he can use charts, desk models, lantern slides, and even his microscope as a means of education. He urged that medical societies take the lead in sponsoring health museums as an aid in educating the public.

## SCIENTIFIC PROGRAMS

The Conference was carefully told by Oscar B. Hunter, M.D., of Washington, D. C., how effective scientific programs could be arranged, allowing time and place for the host society, the specialists, associated organizations, and such ancillary activities as hospital clinics, sports and reunions. Dr. Hunter urged that a place be made for women physicians on the scientific programs.

## GROUP PRACTICE

G. Halsey Hunt, M.D., of the U. S. Public Health Service reported on a survey of group practice

made by his organization. This survey included a study of 102 groups, 84 of which were partnerships. He made the statements that the income distribution of the participants was not an important factor in group practice, and that the majority received a percentage distribution of profits. Dr. Hunt was not too convincing, perhaps because of his youth but more probably from inexperience with surveys.

## SCHOOL HEALTH PROGRAM

The place of the private physician in the school health program was the subject of one of the best presentations listened to by the Conference. Charles H. Keene, M.D., editor of the *Journal of School Health*, outlined the proper program of school health examinations and furnished his audience with a list of the standards a school health program should maintain. He emphasized the value of a coordinating committee which should include county medical society members to execute such a program. All of this is familiar to most physicians in Connecticut since one of our own members, Charles C. Wilson, was chairman of a National Committee on School Health Policies and made a very comprehensive report a few years ago. (See abstract by Joseph I. Linde, *Conn. St. Med. Jour.*, X, i, p. 73.) Dr. Keene could well have filled an hour instead of trying to crowd his mature and experienced deliberations into twenty minutes.

## PREPAID MEDICAL CARE PLANS

James R. McVay, M.D., chairman of the Council on Medical Service of the AMA, opened the subject of prepaid medical care with an historic outline of such plans since 1911, the formation of the Council on Medical Service of the AMA and more recently of Associated Medical Care Plans, Inc. As usual, Jim was factual but he was likewise emphatic. To date there are 85 prepaid plans sponsored by State or county medical organizations, 38 of them indemnity plans, 8 service plans, and 39 combination service and indemnity. These plans have been organized under special legislation, by general statutes, underwritten by private insurance companies, and by the addition of cash benefits to the Blue Cross plans. Too many physicians know little or nothing of these medical care plans sponsored by their own medical societies.

Mr. Charles H. Crowhart, secretary of the Wisconsin State Society, appealed for support of co-



operatives which as now operating include a large group of A. F. L. and C. I. O. members as well as independent unions and farmers. Wisconsin was the first State to pass a law making possible the operation of cooperatives to supply medical care. Associated Medical Care Plans, Inc., was described by its president, L. Howard Schriver, M.D. There are at the present time 45 plans operating under the approval of this corporation with a membership of 7,000,000, and three applications pending. Blue Cross and A. M. C. P. are working together and about 78 per cent of the income from nonprofit plans is being returned to members today. Dr. Schriver opposed both the cooperatives and the placing of medical care plans with line insurance carriers. Dr. Alfred W. Adson of Rochester, Minnesota, poured oil on the troubled waters and very wisely pointed out that in order to defeat the proponents of compulsory health insurance we shall have to utilize every force that will distribute medical care on a voluntary prepayment basis. Physicians listen to Dr. Adson; there must be a good reason.

#### PANEL DISCUSSIONS—PUBLIC RELATIONS

The panel discussions, five in number, occupied the latter part of the first afternoon and reported in abstract to the Conference the second morning. Much of value was talked over and the advice and experience of experts in the various fields added to the interest. In the Public Relations panel, for example, Senator Vandenburg's recent remark was emphasized, to the effect that we have excellent voluntary prepaid medical care plans but have fallen far short in informing the public of them. It was brought out in this panel that the AMA should stimulate the State societies in a public relations program and through them the county organizations and the individual physician. To this end a resolution was passed recommending that the Board of Trustees of the AMA sponsor the formation of a council of representatives of public relations committees from each State society.

#### PANEL DISCUSSIONS—LABOR; FEDERAL AND STATE LEGISLATION

The panel discussion on labor emphasized the value of health councils and the need for labor to be included in these. This panel also felt that the field of organized labor offered the largest sphere of service into which the medical profession should project itself today.

In the panel on legislation Dr. Joseph S. Lawrence, Washington representative of the AMA, contributed his forecast of health legislation in the present Congress. The existence of the Council of State Governments and its efforts to promulgate model State laws were explained. Also it was brought out that there is a law on the statutes permitting osteopaths to operate in VA hospitals, a situation that VA can do nothing about, Dr. Hawley to the contrary. That's but one of the messes he has inherited.

#### PANEL DISCUSSIONS—RURAL MEDICINE; STATE MEDICAL CONVENTIONS

The panel on rural medicine arrived at the conclusion that medical schools should initiate general practice departments and teach students the advantages of rural practice, placing less emphasis on the importance of the certifying boards. Some think there should be a certifying board of general practice. Indiana has such a board. The Section on General Practice of the AMA has not yet approved the formation of such a board nationally.

In the panel discussion on the planning and conducting of State medical conventions solutions were offered for maintaining the interest the final day, such as obstetrical program, a discussion by all the speakers during the convention, a business meeting with election of officers. Where they use the last method they take their politics seriously.

#### SECRETARIES FORUM

Following a dinner for the secretaries on the first evening, Dr. Barker, Dr. Talbot, secretary from Louisiana, Mr. Nelson, executive secretary from Ohio, and Dr. Milloy, secretary from Arizona, presented their views on how the activities of the American Medical Association and State Societies can be better coordinated. The moderator was the secretary from South Carolina, Dr. Julian Price. Any program which finds on it the combination of Barker and Price is bound to be interesting and this one was no exception. They are a great team!

#### THE JOURNAL CLINIC

The journal editors stole the show that evening with a clinic at which the patients were *California Medicine*, *The Wisconsin Medical Journal*, *The Ohio State Medical Journal*, and *The Connecticut State Medical Journal*. The guests of the clinic were Mr. Robert H. Roy, chief engineer of The Waverly Press, Baltimore; Mr. Harry Shaw, general editor of *Harper's*; Mr. John Storm, executive edi-

tor of *Hospitals*; and Dr. Morris Fishbein. It was good. In the first place Mr. Roy held up the *Connecticut Journal* as showing outstanding typographic distinction and being the most legible and attractive of the four journals studied. He called particular attention to the article in the July issue entitled "The Abdominothoracic Approach for High Gastric Neoplasms." Mr. Shaw was most interesting in his appeal for simplicity of expression, not polysyllabic and prolix, but conversational, and emphasized what physicians are prone to forget that there is no such thing as writing but only re-writing again and again. Mr. Storm laid down the criteria of a good editorial, its purpose being to interpret and clarify in a readable form scientific material appearing elsewhere in the same issue. Dr. Fishbein found himself in conflict with some of the opinions of his fellow lay speakers but was thorough in his criticism of the scientific material of the four journals. Connecticut was again complimented for its contributions of high scientific quality, its excellent summaries, and its variety of scientific papers in each issue. Out of such a clinic should come an improvement in all our state medical journals.

The Conference closed with a presentation of the World Medical Association by Louis H. Bauer, M.D., member of the AMA Board of Trustees and delegate from the United States to the WMA. Much of the data submitted by Dr. Bauer appears elsewhere in this issue and in previous issues of the *JOURNAL*. Suffice it to say, the World Medical Association represents the physician in medicine while the World Health Organization represents the government in medicine. The secretary of WMA is to be an American with office in New York City. Dr. Bauer said, "We will get very little out of the World Medical Association but we contribute much to improving the health conditions in the world and to helping doctors in other countries." When Louis Bauer comes to Connecticut in January, don't miss him.

The program of this year's Conference was arranged by a committee headed by Mr. Theodore Wiprud, secretary of the Medical Society of the District of Columbia, in conjunction with Dr. Lull, secretary and general manager of the AMA. It was a fine job. Next year's program committee is headed by Dwight L. Wilbur, M.D., editor of *California Medicine*.

## The World Medical Association

A new international medical society, the World Medical Association, was formed in London on September 18, 1947. The two principal objects of this association, as pointed out by a British observer, are (1) to promote closer ties among the national medical organizations and among the doctors of the world by personal contact and all other means available, and (2) to study and report on the professional problems which confront the medical profession in the different countries.

It was decided that each national medical association should have two votes, one for each of the two delegates, and two votes for the one delegate if the second was unable to be present. It was emphasized in the course of the discussion that the unit of membership is a national medical association and not a country.

The treasurer, Dr. Leuch of Switzerland, in his report pointed out that the funds from the subscriptions of the various national member associations were inadequate for the tasks of the World Medical Association. At this point the American delegates made the generous offer of \$50,000 a year for five years. In discussing this offer, Dr. Louis H. Bauer, one of the delegates from U. S. A., explained that this gift was not from the American Medical Association but had been offered by friends of the AMA, principally industrialists anxious to promote the interests of the World Medical Association. Certain conditions were attached to the gift. One of these, that the headquarters of the Secretariat should be in North America, was approved. After considerable discussion the General Assembly of the Association voted to accept this handsome gift. The editor of the *British Medical Journal* expresses some doubt that if this gift had not been accepted whether the World Medical Association would have remained in existence.

The four American representatives to the World Medical Association were Drs. E. L. Henderson, Louisville, Kentucky, Louis H. Bauer, Hempstead, N. Y., Ernest L. Irons, Chicago, Illinois, and R. L. Sensenich, South Bend, Indiana. The first three are members of the AMA Board of Trustees, the last is president-elect of the AMA. The World Medical Association will be an advisory arm of the World Health Organization which in turn is under the wing of the United Nations.



## Dr. Creadick Appointed by Governor



A. NOWELL CREADICK, M.D.

Dr. A. Nowell Creadick of New Haven has been appointed medical director of Connecticut's new program for care and treatment of the chronically ill, aged, and infirm.

Recently announced by Governor James L. McConaughy, appointment to the new post carries with it responsibility for the medical direction of the first statewide program in the relatively new specialty of geriatrics.

Dr. Creadick has announced that he will discontinue his private medical practice in New Haven to accept the appointment. He has also retired from the chairmanship of the Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm, and has been succeeded in this position by Dr. Joseph H. Howard of Bridgeport, a member of the commission.

A member of the American Medical Association and state and county medical organizations, Dr. Creadick has practiced medicine in Connecticut since 1921. He received his medical degree at the University of Pennsylvania School of Medicine in 1908. From June, 1944 to September of this year he served as president of the Connecticut Cancer Society.

The new state medical program will be initiated the first of January through the adaptation of facilities at the Veteran's Hospital in Rocky Hill for the treatment of chronically ill male patients. A joint activity with the Veteran's Hospital Commission, the facilities will include allocation of 200 of the 600 beds at the Rocky Hill institution. These facilities will be increased as soon as the nursing and medical staffs can be enlarged, Dr. Creadick explained recently.

Future plans calls for the development of facilities for the care of women patients, and the establishment of additional medical centers in other sections of the state, utilizing existing hospitals and convalescent homes insofar as possible.

Dr. Charles T. Bingham of Hartford has been selected by the commission to head its Medical Advisory Committee for supervision of the program. Dr. Bingham has practiced medicine in Connecticut since he received his medical degree at the Columbia University College of Physicians and Surgeons in 1933. He completed his premedical education at Yale University in 1928. Other members of the advisory committee are soon to be appointed, it is understood.

The program at the Rocky Hill Veteran's Hospital will operate as a key plan to guide the development of other facilities throughout the state. Part of the program will be investigative in nature, and cases will be studied with a view to securing data for sound future progress of the plan. Initial medical treatment will be directed toward the care of patients suffering from cancer, arthritis, heart disease, and remediable neurological conditions.

While plans for the use of the Rocky Hill hospital facilities were originally devised to accommodate welfare patients, Dr. Creadick has explained that "ample provision has now been made whereby any physician in the state may refer cases of similar nature on a self-pay basis to this hospital."

Headquarters for the commission have been established in Room 410 in the State Capitol.

The program for state operated facilities for the treatment of the chronically ill and aged was first proposed in a report to the General Assembly in 1943 by the Commission on the Treatment and Care of People Afflicted with Physical or Mental Disabilities, headed by Dr. Creighton Barker. This proposal was supported and further implemented in a report to the 1945 General Assembly prepared by the Research Division of the Public Welfare Coun-

cil, under the direction of Dr. Karl F. Heiser.

Legislation seeking the establishment of an operating program to meet the needs brought to light in these reports and through studies conducted by the Commission on the Care and Treatment of the Chronically Ill, Aged, and Infirm, was introduced in the last session of the General Assembly and was passed almost in its entirety. This action resulted in the allocation of \$900,000 to initiate the program which is now being undertaken.

The commission estimates that of the 250,000 people in Connecticut who are more than sixty years of age, 51,000 are handicapped by chronic diseases and 15,000 of these are at present receiving some form of welfare subsidy, either town relief, old-age assistance benefits, or aid through voluntary agencies.

### Former State Society President Passes Away

Charles C. Gildersleeve, former president of the Connecticut State Medical Society, died in Norwich on November 1 at the age of 81. His ancestors were prominent in New England history as his father was a descendent of the Northport shipbuilders and his mother a cousin of Oliver Wendell Holmes.

Dr. Gildersleeve had practised in Norwich since 1912 and during most of those 35 years served as medical examiner for Norwich, Franklin and Lebanon. He also had been president of the New London and of the Windham County Medical Associations, in 1938 was president of the Association of Yale Medical Alumni, and was a trustee of the Connecticut State Hospital in Middletown.

### Child Health Service Discussed

Dr. Oliver L. Stringfield, of Stamford, regional chairman of the American Academy of Pediatrics, lead a discussion entitled "The National Study of Child Health Services in Connecticut" during the 37th Annual Conference of Social Work held in Waterbury on November 13 and 14.

Participants in the discussion were Dr. J. Harold Root, of Waterbury, state chairman of the study, which is being sponsored by the Academy of Pediatrics; Dr. Martha L. Clifford, director of the Bureau of Maternal and Child Hygiene, State Department of Health; Dr. James A. Dolce, chief of

the Division of Local Health Administration, State Department of Health, Warren B. Sprague, D.D.S., of Woodbury; Dr. Allen Foord, associate administrator, Grace-New Haven Community Hospital; and Irma Biehuse, secretary of the Health Division, Greater Hartford Community Council. Results of the discussion were summarized by Professor Ira V. Hiscock, chairman of the Department of Public Health, Yale University School of Medicine.

### Elected to International College of Surgeons

At the Twelfth Assembly and Convocation of the United States Chapter, International College of Surgeons, held in Chicago at the Medinah Temple on October 3, the following named doctors were among the 810 surgeons inducted into the College:

Fellows: William B. Kaufman, M.D., New Haven; Norman N. Smith, M.D., New Haven; William M. Stahl, M.D., Danbury; Henry J. Giamarino, M.D., New Haven.

Associates: Alphonse A. Beatrice, M.D., Bristol; Egmont J. Orbach, M.D., New Britain.

Affiliate: Michael W. Palmieri, M.D., New Haven.

### Dr. Friedman Resigns at State Hospital

Dr. Emerson Friedman has resigned his position as clinical director at the Norwich State Hospital to enter private practice at Albany, N. Y., where he already has established offices. The resignation became effective November 3.

Dr. Friedman, a major in the army in World War II, has been at the hospital since August 22, 1940. He was on military leave of absence from September 27, 1942, to October 31, 1945.

### N. E. Proctologic Society Meets

The 10th anniversary of the New England Proctologic Society was held at the Hunt Memorial Building, Hartford, October 25, preceded by a dinner at the Hartford Club. The scientific program was arranged and given by the New York Proctologic Society. Election of officers for two years resulted as follows: Albert R. Keith, Hartford, president; H. Leonard Bolen, Fall River, secretary-treasurer; Roy E. Babury, Boston, together with the president and secretary as the executive committee.



## Cost of Operating Medical Schools for 1947-1948 Will Be \$43,000,000

"The cost of operating the medical schools of this country, exclusive of their teaching hospitals, will be somewhat more than \$43,000,000 for the academic year 1947-1948. Less than one-third of this sum will be obtained from student fees," according to an editorial in the August 16 issue of *The Journal of the American Medical Association*.

The editorial states in part:

"The fact that during the coming year medical schools will receive more than \$31,000,000 from endowments, general university funds, gifts and tax sources is good evidence of the determination of university administrators, trustees and legislators to continue to provide a program of high quality in the field of medical education. That such a policy results in a rich return to the people in health, happiness and economic productivity has been demonstrated by experience. It is important, however, to point out that at least one-fourth of our medical schools are still operating on grossly inadequate budgets and that the efforts of many schools are limited by budgets that are but slightly less inadequate. The solution to the problem of how to increase the financial support of medical education is urgently sought in many quarters. During the coming year medical school budgets will be supplemented by grants totaling about \$10,000,000 from foundations, governmental agencies and other extra university sources. Relatively few of these grants are designed primarily to strengthen educational programs. The majority are awarded for the prosecution of specific research problems. It cannot be denied that many grants for research usually benefit the educational activities of the institution receiving them. However, a question that could be raised is whether the fundamental cause of medical education and medical science would be better served if more grants were available for the specific purpose of helping schools strengthen their educational activities. Those responsible for establishing and awarding grants should consider this problem.

. . . A policy of giving more direct financial support to the educational activities of medical schools can be fully justified. As effective research is the product of trained minds whose scientific curiosity has been stimulated, it is reasonable to believe that a greater investment by foundations and similar groups in improving the fundamental training of physicians as a class will ultimately bring

## Your Directory Information Card

Preparations are now being made to publish the new, Eighteenth Edition of the *American Medical Directory*! The last edition of the Directory was issued late in 1942. Since that time, it has been impossible to publish a new edition because of wartime restrictions and the shortage of paper and labor.

About November 15, a directory card was mailed to every physician in the United States, its dependencies, and Canada, requesting information to be used in compiling the new Directory. Physicians receiving an information card should fill it out and return it promptly whether or not any change has occurred in any of the points on which information is requested. It is urged that those physicians also fill out the right half of the card, which information will be used exclusively for statistical purposes. Even if a physician has sent in similar information recently, mail the card promptly to insure the accurate listing of his name and address. There is no charge for publishing the data nor are physicians obligated in any way.

The Directory is one of the most important contributions of the American Medical Association to the work of the medical profession in the United States. In it, as in no other published directory, one may find dependable data concerning physicians, hospitals, medical organizations and activities. It provides full information on medical schools, specialization in the fields of medical practice, memberships in special medical societies, tabulation of medical journals and libraries, and, indeed, practically every important fact concerning the medical profession in which anyone might possibly be interested.

Therefore, should any physician fail to receive one of these Directory Information cards by December 1, he should write at once to the Directory Department requesting a duplicate card be mailed.

a much larger return in scientific knowledge and scientific practice than will the expenditure of funds almost exclusively in support of the special activities of a few selected investigators."

## Connecticut TB Association Meets

Dr. William M. Morriss, medical director of Gaylord Farm Sanatorium, Wallingford, was elected president of the Connecticut Tuberculosis Association at the annual meeting of the organization in New Haven November 4.

Henry F. Powers, president of the Uncas Merchants National Bank, Norwich, was elected treasurer, and Dr. Joseph I. Linde, New Haven, was re-elected assistant treasurer. Others re-elected to office were Dr. Charles C. Wilson, Yale University, and Mrs. Frederic R. Briggs, Stamford, vice presidents; and Mrs. Edward F. Ryan, Southbury, secretary.

Approximately 200 tuberculosis and health officials attended the meeting and dinner, held at the New Haven Medical Association Library.

Guest speaker for the occasion was Dr. James E. Perkins, deputy commissioner, New York State Department of Health, and recently appointed managing director of the National Tuberculosis Association. Tracing the progress of the fight against tuberculosis in the United States, the speaker advocated consolidation of health examinations to obviate difficulties now being experienced in the duplication of examinations by voluntary and public health agencies.

"It is beginning to look rather silly," he declared, "to go through sections of the population taking x-rays for the discovery of tuberculosis, and then to have other organizations repeat examinations for these groups to discover other diseases." He recommended complete physical examinations as the solution to this problem.

Commenting on the rapid spread of tuberculosis in foreign lands, the speaker declared that "tuberculosis is today the Number One health problem in Europe."

Elected to the executive committee of the association were: Dr. Cole B. Gibson, Meriden; Mrs. Henry F. Baker, Greenwich; Mrs. M. Gilbert Burford, Middletown; and Mrs. John S. Tufel, Waterbury.

## AMA Nursing Care Committee Meets

The first meeting of the newly organized committee of the American Medical Association to study the nation's problems of nursing care was held recently in New York City.

Heading the committee is Dr. Thomas P. Murdock, of Meriden, chairman of the State Medical Society's governing council. Committee members include Brigadier General Warren V. Draper, assistant director of the United States Public Health Service; Dr. Donald C. Smeltzer, Philadelphia, formerly president of the American Hospital Association; Dr. Lester R. Dragstedt, Chicago, member of the American Surgical Association's committee to study nursing problems; and Dr. Wingate Johnson, professor of medicine, Bowman-Gray Medical College, Winston-Salem, North Carolina.

In defining the scope of the committee's study, Dr. Murdock states that "we plan to approach the nursing problem on the basis of the number of nurses in the United States at the present time; the number needed; the number of students in nursing schools and the number that should be enrolled. The matter of retirement funds, the economic problem, curricula in the nursing schools, the question of increasing or lowering of nursing standards, and the question of courses for bedside nursing and administrative work also will be considered."

## Survey Medical Education

Plans are now under way to make the comprehensive survey of medical education recently authorized by the A.M.A. Board of Trustees. The A.M.A. Council on Medical Education and Hospitals will be joined in the survey by the Association of American Medical Colleges. The A.M.A. council and the executive council of the college association already have discussed plans for the survey at a joint meeting, and a temporary planning committee, consisting of three representatives of each group, has been appointed.

The A.M.A. council is being represented by Drs. H. G. Weiskotten, Syracuse, N. Y.; Victor Johnson, Rochester, Minn.; and Donald G. Anderson, Chicago. The college association representatives are Drs. A. C. Bachmeyer, Chicago; Joseph C. Hinsey, New York; and Walter A. Bloedorn, Washington.

This planning committee held a two-day meeting in Chicago, September 6-7, to proceed further with the organization of the survey.

In view of the recent advances in medical knowledge and the nature of medical care, a careful re-evaluation of the curriculum of the various medical schools is planned.



## BEGIN WITH THE PEOPLE

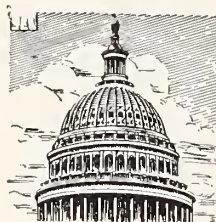
The problems of providing medical care can be solved only with the help of all kinds of people — the support of the man in the street.

All people have opinions. They express them freely because they are trying to answer questions for themselves.

What People Think About  
Medicine Is Important

## COMMITTEE ON PUBLIC POLICY AND LEGISLATION

*Fairfield County*, Charles H. Sprague, Bridgeport  
*Hartford County*, Benjamin B. Robbins, Bristol  
*Litchfield County*, W. Bradford Walker, Cornwall  
*Middlesex County*, Richard H. Grant, Cromwell  
*New London County*, Edmund L. Douglass, *Chairman*  
 Groton  
*New Haven County*, Charles T. Flynn, New Haven  
*Tolland County*, Leonard W. Levine, Ellington  
*Windham County*, Brae Rafferty, Willimantic

PUBLIC  
AFFAIRSDoctors Visiting Alaska Find Health  
Conditions Deplorable

Deplorable health conditions in Alaska, made more acute by its sudden increase in population, can be remedied only by much greater federal financial aid and outside assistance in the form of trained personnel. This is the consensus of the team of five physicians, appointed by the advisory committee of the American Medical Association to the Department of the Interior, who recently toured the territory of Alaska for three weeks to study its overall medical conditions and problems. After arriving in Alaska on July 19 the team toured a total of about 4,500 miles, visiting all important parts of Alaska with the exception of the Aleutian chain. Everywhere they went they consulted physicians of the Alaska Native Service, private practitioners, military and health officers, nurses, local and territorial officials, and school teachers. They pored over statistics. They examined several hundred patients and performed several operations. They investigated hospital and housing facilities, sanitation and engineering work, and personnel problems.

"Tuberculosis constitutes the most urgent and important health problem in Alaska," they observe, pointing out that Alaska's overall death rate from tuberculosis of 359.1 per 100,000 for the year 1945-1946 is probably one of the highest in the world. It is nine times the overall rate in the United States, and if the native rate were computed separately it would probably be 14 times the rate in the states. A school teacher at Barrow told the doctors that of 30 children between the ages of five and six who had entered school only six lived to finish—and the majority of deaths were due to tuberculosis!

The doctors believe that lack of isolation of tuberculosis cases should get a large share of the blame for the tuberculosis rate: in the native vil-

lages most of the housing is so poor that as many as 11 persons could be found living in a single room about nine by 12 feet. Yet there were only two reconverted army hospitals with a total of 250 beds available for the special treatment of tuberculosis, and one of these was about to be scuttled because a deficiency appropriation had failed to pass Congress. Furthermore, the doctors report, "the after care and rehabilitation of tuberculosis patients is almost a nonexistent project in Alaska."

"In the face of all this," the doctors write, "Congress has seen fit to reduce the already meager funds of the Alaska Native Service for the care of the tuberculous."

In addition to tuberculosis, the doctors noticed a high incidence of eye disease among natives in the territory, which does not have a single qualified ophthalmologist. The doctors state that venereal disease is another extremely serious medical problem, especially in the larger cities with their recent influxes of defense workers, and in military posts.

"Additional funds or their equivalent in personnel or drugs for other venereal control measures is needed," they write. "A separate person should be in charge of the Division of Communicable and Preventable Disease Control. . . . The U. S. Public Health Service should supply the director as well as sufficient financial aid to assist Alaska in its fight against venereal and other communicable diseases. . . . The problem of venereal diseases among the military makes it one for federal subsidy."

Alcoholism was still another problem. "Alaska has been cited to the committee as having a larger per capita rate of alcohol consumption than any state," the doctors write.

Outbreaks of typhoid fever, diphtheria, measles and influenza had all occurred in epidemic proportions in Alaska, but the doctors state that none of the existing hospital facilities provided beds for the



isolation of communicable diseases. Epidemic breeders were inadequate housing, a rapidly expanding population and poor sanitation.

#### SANITATION, HOSPITALS AND HOUSING INADEQUATE

In sanitation the doctors report that the Division of Sanitation and Engineering was making progress in face of great difficulties: shortage of personnel, great distances between inhabited points, and unfavorable climate, particularly in the arctic. They found great need for major improvements in public water supply and sewerage systems.

The Territorial Department of Health and the Alaska Native Service were also suffering from personnel shortages, the doctors reveal. "The resultant lack of medical care reflects on the overall health conditions of the territory," they write. "The reasons for the personnel problems can be attributed to the following factors: high cost of living in the territory; isolation of the individual in remote communities away from professional contacts, and, finally, the housing shortage."

"The general hospitals of the territory are grossly inadequate to meet the medical needs of Alaska," they continue, adding that most of the existing hospitals were fire hazards. No facilities of any type existed for mental patients, and only one physician in the entire territory practiced psychiatry.

"The acute housing shortage in Alaska enters into every phase of a discussion about the territory," the doctors conclude, recommending active federal participation in solving this problem, too. "Not only is the quantity of housing appallingly insufficient, but the quality throughout the territory is extremely bad. It can be stated conservatively that 50 per cent of the housing in Alaska is substandard. Hundreds of houses in the coastal towns are built on piling over tidewater, and many have large and ancient accumulations of garbage and sewage beneath them. Hundreds of families, particularly in the vicinities of Anchorage and Fairbanks and along the highway, are living in huts, cabins, hovels, tarpaper shacks, tents and trailers. These dwellings are not situated where standardized and supervised facilities for water supply, sewage and garbage disposal exist."

#### American Legion Medical Program

The following recommendations of the National Medical Advisory Board of the American Legion have been made for the 1947-48 program, and endorsed by its rehabilitation executive committee at

its meeting in New York City, August 27, 1947:

1. That a suitable resolution be prepared by the National Rehabilitation Committee and submitted to the National Convention for their approval requiring the appointment or election of a Department Medical Advisor in every Department and a Post Medical Advisor in every Post, both to be doctors of medicine.

2. The establishment of an "American Legion Medical Forum of the Air," in cooperation with the national public relations division of the American Legion.

3. To the National Commander and to the Rehabilitation Executive Committee that the American Legion favors medical research in all its phases.

4. Continued effort to promote and enhance the American Legion's and American Legion Auxiliary's program on rheumatic fever and rheumatic heart disease and its volunteer cooperation effort with the American Council on Rheumatic Fever of the American Heart Association. The American Legion's action has already been productive of a well organized national program in rheumatic fever and rheumatic heart disease by the American Council on Rheumatic Fever of the American Heart Association.

5. That we approve of the residency program and the Dean's Committee as set up throughout the nation by the Veterans Administration and further recommend its extension to Veterans Administration outpatient clinics. We believe that this approach assures the veteran the best medical care possible. That the outpatient service, though good in many respects, should be improved and strengthened on a sound and lasting basis.

Adequate outpatient medical service should be made to meet the needs of the vast majority of sick veterans. In fact, in many instances, this service is more important to the veteran than that obtained in hospitals. Improvement in the outpatient clinic is, in our opinion, a great factor in the reduction of the need for the hospitalization of the veterans who may need such treatment.

We believe consideration should be given by the VA to the adoption of an intern service in the hospitals where it is appropriate to the possibility of introducing clinical clerkships in the teaching hospitals and these be under the direction of the resident staff and the supervision of the Dean's Committee.

Since diagnosis and home treatment is the essence of clinical service, the residency program should

involve training of all residents in the work of out-patient clinics.

Whereas the medical and surgical staffs of Veterans Administration hospitals will shortly be depleted by the loss of temporary assignments of military personnel, therefore, it is the recommendation of the Board that the Congress be petitioned to enact adequate legislation to permit internships in veterans hospitals.

6. That while we believe that the Veterans Administration hospital care, especially in larger hospitals, has improved and is in fine condition, yet we urge constant effort to keep that service at its highest efficiency.

7. The Board is cognizant from the reports of the Veterans Administration of the abuses that have occurred under the methods inaugurated by them in their endeavor to obtain the maximum amount of medical and dental care for the veteran under the home-town program in the time when the need is most pressing. However, it is now felt that many of these conditions that seem to be out of proportion to the situation as now exists could be eliminated by a careful study by the medical and dental groups within the state having executed a contract for this service. In a project of such great magnitude, abuses are bound to occur. Where evidence of such abuses are apparent, it is recommended that they be called to the attention of the licensing board in the state where it occurs, and that a copy of this be submitted to the local county society concerned.

8. That in the treatment of veterans, it is a time proven fact that veterans in the professions understand and are peculiarly equipped to treat veteran patients because of their understanding born of their actual and common experience, and therefore recommend that all members of the medical and dental professions who are veterans be given first consideration in the appointment and training under any program inaugurated by the Veterans Administration. The Board, however, realizes that the tremendous task of the care and treatment of veterans requires a greater number than the actual number of available veterans in these professions. Veterans preference should hold, however, for doctors, dentists, and nurses, all other things being equal.

9. It is recommended to the Congress of the United States when economy is to be practised in the Nation, it should not be at the expense of the health of the veterans who saved the Nation.

## Organized Nursing Speaks Its Mind

Speaking for its 155,000 registered professional nurse members, the American Nurses' Association issued a statement to the public October 8 on the critical situation in nursing facing the American people. This statement was issued from the national headquarters office in New York City through the Association's executive secretary, Ella Best. It declared that "the public must be roused to a clearer understanding of the present crisis in nursing if the situation is to be met and the health of the American people is to remain safeguarded."

The statement analyzed the underlying problems in the present nursing crisis and outlined a three-point program by the Association designed to aid in enlisting the cooperation of other groups to help solve the problem. The American Nurses' Association has appropriated funds, has appointed a public relations committee with Harriet Stambach, R.N., as chairman and has retained Edward L. Bernays, counsel on public relations.

Pointing out that the demand for nurses has skyrocketed in the last few years, both during and since World War II, the ANA statement indicated that a number of factors are not only deterring would-be nurses from joining the profession but are discouraging many nurses who are already registered, from continuing their professional activity.

These facts were defined as:

1. Inadequate economic security and unsatisfactory conditions of employment.
2. Lack of adequate legal control of nursing by the States.
3. Faulty distribution of nursing service.

The ANA statement said that at the present time there is wide variation in the standards for accredited schools of nursing and for registration of professional nurses in the several states. The first registration law was enacted in 1903 and since that time forty-eight states, the District of Columbia, Alaska, Hawaii and Puerto Rico have passed laws providing standards for the registration of professional nurses. Only twenty-six states and Hawaii and Puerto Rico, now have laws providing licensure for practical nurses. Only two states have laws requiring licensure of all who nurse for hire. Without such laws in all states the public is at the mercy of many unqualified and unlicensed persons.

Katharine J. Densford, president of the American



Nurses' Association, in October urged the governors of all forty-eight states to call state-wide conferences "at the earliest possible date" to consider concrete measures to resolve the nursing crisis created by increased demands for nursing service now facing the American public.

Pointing out that the nursing profession is united on a program of action, Miss Densford, in telegrams to each governor, called for effective action in every state of the union.

"I made a nation-wide telephone roll call from Minneapolis on October 20 to get the support and cooperation of the forty-eight presidents of the state nurses' associations," Miss Densford wired. "The ANA, representing 155,000 professional registered nurses, received wholehearted support from the State association presidents on three major points of the ANA's program: 1. Make nursing care equally available to all by intensifying efforts of the ANA's counseling and placement service for the best possible use of available nursing service, and provide a continuing supply of nurses by promoting recruitment; 2. improve nurses' working conditions, rates of pay, personnel practices, and see that nurses share in the administration of nursing services; 3. protect the public by adequate legal control of nursing practice, both professional and practical.

"We in ANA are doing everything in our power to rouse the public to a clearer understanding of the nursing crisis, because nurses cannot singlehandedly solve the problem," she wired each governor. "Effective action is needed at once in every State of the Union. As president of the American Nurses' Association I am respectfully requesting the governors of each state to cooperate with us.

"Specifically, I ask you to call on the president of your State nurses' association, and the head of every group interested in public health and public service, to meet at a state-wide conference under your auspices at the earliest possible date to consider concrete measures resolving the nursing crisis now facing the American public. I shall deeply appreciate a prompt reply from you indicating what cooperation you can give this public situation," she concluded.

## NEWS FROM WASHINGTON

One of the most important things that has happened since the adjournment of Congress is the publication of the report of the *President's Com-*

*mittee on Scientific Research*, which was formed in October, 1946, by executive order. It originally consisted of fourteen members, under the chairmanship of John R. Steelman, assistant to the President, and J. Donald Kingsley, executive secretary. Later, another sixteen persons were named as a Board of Alternates. The committee's report, because of its length, is divided into five volumes, and a brief summary of each follows:

The first volume, entitled "*Program for the Nation*," reports that only a very small part of our total research and development resources of health and medicine is devoted to the expansion of medical research. It recommends that when, and if, the National Science Foundation is created, that it become part of the proposed department of health, education and security.

The second volume, "*Federal Research Program*," reviews the types of research that are now being performed by, or under the auspices of, the Army, Navy, Agriculture, and other executive departments and bureaus.

The third of these, "*Administration for Research*," recommends the establishment of a National Science Foundation, the creation of a special unit in the Bureau of the Budget to review all scientific programs, and the formation of an interdepartmental committee on scientific research and development with the designation of a liaison officer on scientific problems inside and outside the Government.

"*Manpower and Research*," volume four, makes three general recommendations: (1) Subsidize colleges and universities in order that they might improve their plants and increase the salaries of instructors; (2) Focus attention on basic research; and (3) Develop a national system of scholarships and fellowships.

Volume five, which was received on October 18, is entitled "*The Nation's Medical Research*" and is divided into three parts:

Part I. Problems of Medical Research.

- (a) Barriers to Medical Research.
- (b) Methods of Financing Medical Research.
- (c) Medical Research Personnel.

Part II. Federal Program and Problems.

- (a) Organization and Administration of Medical Research.
- (b) Administration and Research Personnel.
- (c) Federal Research Grants, Contracts and Fellowships.

(d) Content of Research Program.

(e) Medical Research Facilities.

Part III. Conclusions and Recommendations, which in condensed form are:

1. National expenditures for medical research should reach \$300,000,000 annually—nearly three times the present amount.

2. Federal support should supplement—not replace—other funds.

3. The Federal Government must take the lead in stimulating fundamental research.

4. The National Institute of Health junior and senior fellowship programs should be expanded. Senior fellowships should be lengthened from one to at least two years and an option provided for additional years in special cases.

5. Medical Research scientists should be included in the policy-making structure and given some responsibility and authority in budgeting and personnel processes. Salaries up to \$15,000 should be authorized.

6. To the extent permitted by law, the agencies should attain uniformity of procedure in matters of budgets, methods of payment, property return, accounting and audit, and terms of contract.

7. The Federal Government should continue its sound policy of utilizing outside scientific advisers. It must, however, resist any tendency to create medical research monopolies.

8. Cancer, venereal diseases and tuberculosis are high in the list of diseases under investigation at present and to the extent permitted by law, the agencies of the Government should move promptly to increase research effort to those diseases and impairments (diseases of the heart and arteries, diseases associated with middle and old age, acute respiratory diseases, mental and dental diseases) which are now receiving insufficient attention, but which are major causes of death and disability.

9. An advisory committee of Government and non Government medical scientists should be established at once. It should be wholly advisory and should concern itself with large scale and long range planning for a national medical research policy.

The House Committee on Ways and Means, of the 79th Congress, made a study of the Social Security Act, with particular reference to old-age and survivors insurance, and the problems of cover-

age benefits and taxes related thereto. The Committee published its findings in a voluminous report, *recommending continuance and extension of social security*. The Senate of the 80th Congress, by resolution, authorized its Finance Committee to undertake a similar study—"to make a full and complete investigation of old-age and survivors insurance and all other aspects of the existing social security program, particularly in respect to coverage benefits and taxes related thereto"—in order that the Committee may be prepared to deal with this character of legislation which may originate in the House of Representatives.

The latest discovery in the health field by the Harness Committee of the House of Representatives is that a Government representative is authorized to attend an I.L.O. Conference meeting, to be held in the near future, in Delhi, India, for the purpose of *drafting a Government Health program* for India.

In accordance with the Act of Congress, which requires the Federal Bureaus and Departments to provide "on the job" medical service for their employees, the Public Health Service has begun *surveys of employee health programs* in the Federal units. The largest single study is being conducted in Denver, Colorado.

## The Government Health Mission to Tokyo

Federal Security officials in Washington put one over on the Surgeon General of the War Department, Congress and the public by getting off to Japan a government health mission, ostensibly to assist the government in Japan with its health problems but actually to advance socialized medicine in that country. Colonel H. W. Doan, MC, executive officer in the Office of the Surgeon General in the War Department, after conferring with Surgeon General Bliss left for a two months' visit in Japan. General Bliss was not consulted about the plans for the health of the Japanese when the mission to Japan was being worked out by Federal Security officials.

In a letter to Chairman John Taber of the Appropriations Committee, Representative Forest A. Harness (R., Indiana), chairman of the subcommittee investigating government publicity and propaganda, has shed more light on this so-called health mission. The full text of the Harness letter follows. It should be read with care.



CONGRESS OF THE UNITED STATES  
HOUSE OF REPRESENTATIVESSubcommittee on Publicity and Propaganda of the  
Committee on Expenditures in the Executive  
Departments

September 9, 1947

Honorable John Taber  
Chairman, Committee on Appropriations  
House of Representatives  
Washington, D. C.

Dear Congressman Taber:

The subcommittee investigating publicity and propaganda in the executive agencies, of which I am chairman, learned recently that the Social Security Administration, the U. S. Public Health Service, and the Public Housing Authority have sent a special health mission to Tokyo with a view to assisting in the formulation of a new national health program for Japan. This mission is operating on a temporary basis as a function of the War Department.

In a letter addressed to Mr. Watson B. Miller, Administrator of the Federal Security Agency, under date of August 6, 1947, the Secretary of War stated the objectives of the mission were "to consult with the Public Health and Welfare and with the Japanese Committee on Social Insurance and Japanese Council on medical care for the purpose of drafting a national health bill which will incorporate a unified national health program with a national medical care program. This bill must be available to present to the Diet not later than October 1, 1947."

I deem it proper to bring this matter to your attention because it appears to me to involve a question of legislative policy for the consideration of the Appropriations Committee. All members of this mission are permanent, full time employees of the federal government and are well known in the United States for their persistent agitation for a national system of socialized medicine to be achieved through a program of compulsory health insurance. The members of the mission are:

Joseph W. Mountin, associate chief, Bureau of State Services, U. S. Public Health Service.

Burnet M. Davis, surgeon, U. S. Public Health Service.

Barkev S. Sanders, chief, Health Studies Division, Bureau of Research and Statistics, Social Security Administration, and

Francis A. Staten, assistant regional director for management, Federal Public Housing Authority.

This mission departed for Tokyo on August 28, 1947. We are informed that at later date the mission will be expanded to include Mr. Arthur J. Altmeyer, commissioner of the Social Security Administration; Mr. Wilbur Cohen, assistant director of the Bureau of Research and Statistics, and possibly Mr. I. S. Falk, director of the Bureau of Research and Statistics.

In reply to allegations by the War Department that protests against this mission have been based on lack of information, please be advised that my statements are founded upon what purports to be the complete file of the War Department in this matter. These files indicate definitely that the plans for the mission were originated by key agitators for socialized medicine on the federal payroll in Washington and their collaborators on the federal payroll in Tokyo; that very close liaison was maintained among the two groups, and that the basic purpose of the mission is the establishment of socialized medicine in Japan.

In preparation for the mission, a civilian employee, Mr. Stanchfield, was sent to Tokyo to make a preliminary survey of social security and health needs. Thereafter Mr. Stanchfield proposed the mission to Arthur J. Altmeyer, commissioner of the Social Security Administration, and on March 5, 1947, Mr. Altmeyer in a letter to the War Department designated the personnel to be included in the mission, and suggested Mr. William H. Wandel, chief of the Program Division, Bureau of Unemployment Security, as a member, and suggested that Mr. Wandel precede the mission to Japan by about three months and that he should remain three months after the mission had completed its visit to Japan to finish up any necessary details, and he further suggested that while in Japan on the mission, Mr. Wandel serve as chief, Social Insurance Division, Public Health and Welfare Section of the Supreme Command for the Allied Powers (SCAP).

It is apparent from the letter herein referred to from Mr. Altmeyer to the War Department that the personnel of the mission and the planning of its program was dictated and originated in and from the Social Security Administration in Washington. There is nothing in the entire record before us to indicate or suggest that the need for the mission was suggested originally either by General MacArthur or any responsible Japanese source. To the contrary, our records contain a letter under date of June 14, 1947, from William H. Wandel, chief of the Social

Security Division, Public Health and Welfare Section of SCAP, to I. S. Falk in Washington, outlining the real purposes of the proposed mission. In this letter Mr. Wandel said in part:

"We now think that our need is for someone who is primarily not so much an economic analyst as one versed in health insurance. Health insurance is the major field of social security in Japan. . . . Permanent revision requires amalgamating National Health Insurance with Health Insurance, on a compulsory basis."

In a letter from William H. Wandel from Tokyo to I. S. Falk of the Federal Security Agency, Mr. Wandel exposed the fact that there were conflicts of interests as to the purposes to be accomplished when he stated:

"I find the work here very interesting and engrossing. One is reminded forcibly of the apparently universal character of the conflict of established interests, but nevertheless there are real possibilities for accomplishment. I am glad I came out."

It has also come to the attention of our Committee that Dr. B. M. Davis, one of the members of the Tokyo mission returned only recently from London, where he was attached to the British Ministry of Health, to assist in the national program for socialized medicine in England. He is the son of Mr. Michael M. Davis, chairman of the Executive Committee of the Committee for the Nation's Health, the foremost lay organization agitating for socialized medicine in the United States, as embodied in the Wagner-Murray-Dingell bill. The Committee for the Nation's Health, as our previous reports have delineated, is the principal national organization in the United States engaged in distributing the propaganda of the Social Security Board supporting socialized medicine.

I feel strongly that the question fairly arises as to when these gentlemen work for the people of the United States who pay them? Our Committee has already traced out their operations in New Zealand, in England, in Latin America, and finally in Japan. Personally, I feel that if the American taxpayers are supporting a world-wide movement for socialized medicine, then the people are entitled to know it and to know how much such international activities are costing them.

We have been investigating this situation for six weeks. Our conclusions to date are as follows:

1. That the health mission to Japan is composed entirely and exclusively of men long identified in

the public record as advocates and proponents of socialized medicine not only in the United States but throughout the world.

2. That the real purpose of this mission is to lay the ground work for a system of socialized medicine in Japan.

3. That the scheme for such a mission originated in the Division of Research and Statistics in the Social Security Board in Washington, and nowhere else.

4. That the nominal request for the mission was engineered through the General Headquarters of the Supreme Commander in Tokyo by federal employees sent from Washington for that particular purpose.

5. That General Douglas MacArthur does not favor—and does not approve—any plan to establish compulsory socialized medicine in Japan.

6. That the dispatch of this mission to Tokyo for the purpose indicated in Mr. Wandel's letter to Mr. Falk under date of June 14, 1947, is a gross misuse of public funds.

7. That the real purpose of the mission is not to assist Japan in working out her basic problems in health and welfare, but to force upon that country a compulsory system of socialized medicine.

8. That although the questions here involved are of a health and medical nature, the Surgeon General of the United States Army was not consulted in reference to the problems involved.

I deem it inappropriate for federal employees, at the expense of the American taxpayer, to travel throughout the world preparing or assisting in the preparation of legislation to be adopted by foreign countries when similar legislation, long pending, has not been approved by the Congress of the United States.

We are continuing our investigation of the origins and real purposes of the Tokyo health mission. Meanwhile we believe that your Committee would want to have these facts before it when the next appropriation bill comes up for the Public Health Service and the Social Security Board.

I am most anxious to cooperate with your Committee, and will be happy at any time to make available to you or your staff the documents assembled by the staff of my Committee in regard to this matter.

Sincerely yours,

Forest A. Harness



## Congress Uninformed on New Wagner-Murray-Dingell Bill

From Marjorie Shearon before the Welfare Committee of the Medical Society of New Jersey:

"There is a real threat this year because Congress is totally uninformed (on the health bills). They do not know what is in the bill (Wagner-Murray-Dingell) with the exception of two or three of them. Medicine and other groups with a common interest should get together instead of each group playing tidley winks by itself."

## Program for General Practitioners at AMA Cleveland Session

In addition to technical and scientific exhibits, a program designed particularly as postgraduate education for general practitioners will be presented at the supplemental session of the American Medical Association in Cleveland, Ohio, January 5-9, 1948.

The Council on Scientific Assembly, whose chairman is Dr. Henry R. Viets of Boston, has prepared a program which will include papers, panel discussions and symposia on many of the topics now most prominently before members of the medical profession. Among the topics to be covered are peptic ulcer; blood dyscrasias [any abnormal composition of the blood]; the chronic invalid; post-hospital care of patients with cancer; treatment of the fat and the lean; cancer of the prostate; the use of BCG [Bacillus Calmette Guérin] vaccine in the prevention of tuberculosis; uterine hemorrhage; multiple injuries in automobile accidents; the treatment of pathologic conditions in adolescence; the treatment of the healthy and sick diabetic patient; jaundice; the Rh factor; and the interpretation of x-ray films of the chest.

During the first two days of the session the Council on Industrial Health of the American Medical Association will conduct a program devoted particularly to problems in its field.

Planned for the Scientific Exhibit is a demonstration of the operation of a diagnostic cancer clinic, in which visiting physicians will be given the opportunity to undergo themselves the routine of such an examination.

## THE DOCTOR'S OFFICE

David S. Babtkis, M.D., announces the resumption of the practice of medicine at 505 Atlantic Street, Stamford.

Maurice H. Bisharat, M.D., announces the opening of an office for the general practice of medicine at 251 Main Street, Torrington.

Sidney L. Cramer, M.D., announces the opening of an office for the practice of radiology at 64 Garden Street, Hartford.

Isaac Horowitz, M.D., formerly roentgenologist in charge of the Hartford regional office of the Veterans Administration, announces the opening of an office for the practice of roentgenology at 1336 Fairfield Avenue, Bridgeport.

Morris Y. Krosnick, M.D., announces the removal of his office to 38 Trumbull Street, New Haven. Practice limited to pediatrics and pediatric allergy.

Ashley W. Oughterson, M.D., announces the opening of an office at 38 Trumbull Street, New Haven.

Daniel J. Sabia, M.D., announces the removal of his office from 15 Broad Street to 65 South Street, Stamford.

Sydney A. Solway, M.D., announces the opening of an office for the practice of medicine at 195 Post Road, Darien.

Raymond Zagraniski, M.D., announces the opening of an office for the general practice of medicine at 977 Whalley Avenue, New Haven.

## Motion Picture Films

To assure the listing of all outstanding medical and surgical motion picture films in the revised "Catalogue of Professional Motion Picture Films" now being compiled, *all* film authors are urgently requested to immediately write for film questionnaires to be filled out and returned. All members of the profession are invited to cooperate with this undertaking by forwarding this announcement to an author or by furnishing the film title and full name and address of any film author. Send information to: Academy-International of Medicine, 214 West Sixth Street, Topeka, Kansas.

## Army Doctors and Dentists to Get Extra \$100 a Month

Major General Raymond W. Bliss, Surgeon General of the Army, announced recently that effective September 1 an additional \$100 a month will be paid to all Regular Army Medical and Dental Corps officers as well as other officers serving voluntarily on extended active duty in these Corps.

General Bliss emphasized that this addition to the incomes of medical and dental officers is regarded by the War Department "not as a pay increase but as an equalization measure designed to bring the incomes of Medical and Dental Corps officers more nearly in line with those of civilian doctors and dentists."

General Bliss explained that "the additional compensation will also aid in reimbursing the medical and dental officers for the costs of their professional education and for their loss of earnings while in medical or dental school."

The Army will also follow a new policy of commissioning selected doctors and dentists in the Regular Army in grades as high as full colonel depending upon their age and professional qualifications. In the past, medical and dental officers entering the Regular Army have been initially commissioned only as first lieutenants. Wartime officers have been integrated into the Regular Army in grades through that of major. The measure authorizing appointment of Regular Army Medical and Dental Corps officers in advanced grade also provides for such officers to be credited, for purposes of promotion, with the minimum number of years of service "now or hereafter required for promotion of officers of the Medical and Dental Corps to the grade in which appointed."

The Surgeon General explained that these important changes in the Army's medical program have been made possible by legislation passed by Congress on July 26 and signed by President Truman on August 5. This measure is in the form of an amendment to the Pay Readjustment Act of 1942.

General Bliss said the \$100 increase in compensation for Army medical and dental officers will benefit not only Regular Army but also Reserve, National Guard and Army of the United States officers. Former students of the Army Specialized Training Program who are required to serve on extended active duty are eligible for this increase

in compensation when they apply for and are accepted into the Regular Army. Under study at present is the length of time which these Army Specialized Training Program-trained officers must serve on active duty before becoming eligible to apply for the regular establishment. This policy will be announced when formulated.

The enabling legislation limits the duration of these benefits to thirty years of active service.

The extra \$100 monthly compensation will be paid not only to officers who are on extended active duty as of September 1, the effective date of the legislation, but to all eligible Medical and Dental Corps officers who are commissioned in the Regular Army, or volunteer for extended active duty within the next five years.

The Surgeon General stated that the enactment of this, and other legislation including the "Officer Personnel Act of 1947," which established an accelerated promotion schedule, will enable the Army Medical Department to offer much greater advantages than it has in the past to doctors and dentists seeking careers in the governmental service.

## Publicize Report Absolving Doctors on Retiring Board, Journal Asks

The investigations of a committee appointed by the War Department, which were instigated by criticisms made against the machinery of the retirement of army officers, "should be made public so that even the shadow of suspicion may be removed from the medical members of the Disposition and Retiring boards," according to an editorial in the February 8 issue of *The Journal of the American Medical Association*.

The editorial follows in full:

Last year both the Reserve Officers Association and the National Guard Association criticized the machinery of retirement of army officers, claiming discrimination against the civilians who had served with the Army. Resolutions were passed by both organizations charging unfairness and favoritism; indeed, charges were made that laws and regulations were being purposely misinterpreted.

Retirement procedure in the Army is largely a medical function. The officer to be retired is first given a physical survey in a hospital; he then appears before a disposition board, all the members except the recorder being physicians. Finally he appears before a retiring board, with at least two medical



members. Medical witnesses familiar with the case are called to testify, and the board proceedings are reviewed by physicians in the War Department. Because of this method of procedure, the censure of the resolutions passed by the two associations would seem to fall on medical shoulders even if it was not so intended.

The complaints were so serious that the War Department appointed a committee to make a careful investigation. The committee was composed of officers from all components and represented various branches of the service. The results of the investigation have never been made public. It is understood, however, that the committee devoted much time to its work and made a thorough and complete investigation. The findings of the committee did not substantiate the charges made by the two organizations. The committee found, however, that medical officers, the vast majority of whom were from civilian life, were conscientious in their work and that their findings were in accord with the laws and regulations governing retirement. Errors may have been made in individual cases, but these were few and were largely matters of professional judgment and opinion.

The committee report should be made public so that even the shadow of suspicion may be removed from the medical members of the Disposition and Retiring boards. The splendid body of men who volunteered their services in the war effort certainly did not indulge in double dealing or chicanery.

### **New Laboratory Established for Routine Rh Blood Tests**

The Rh blood factor, discovered in 1940 after experimentation with rhesus monkeys, is an important substance which is lacking in Rh negative people. When such people receive Rh positive blood, which does contain this factor, either by transfusion or through the common circulation of a mother and child during pregnancy, dangerous reactions may set in. One which affects the child is known as erythroblastosis, a combination of jaundice and anemia caused by Rh incompatibility.

The idea for the laboratory is credited to a number of obstetricians in Baltimore who deemed it essential to establish facilities for routine Rh studies at a minimal cost for any clinic or private patient in the city.

The laboratory, which began to function on

August 1, 1945, is under the jurisdiction of a committee of six members of the Obstetrical and Gynecological Section of the Baltimore City Medical Society. It is a privately sponsored, cooperative community venture. The services of the laboratory are offered free of charge to the dispensary patients of any hospital within the city and to patients of the City Health Department Obstetrical Clinics. Private patients pay \$3 or \$5, depending on the extent of services desired. "The initial charge is the only one," state the authors. "All subsequent studies throughout pregnancy are made without further cost to the patient. Similar arrangements have been made available to physicians in the counties of Maryland."

The authors state that "during the first eight months of its existence, the laboratory performed tests on approximately 7,000 pregnant women. There were approximately 12,000 births in Baltimore during a similar period."

Women patients who come to this laboratory are tested for sensitization to the Rh factor. That is, a test is made to determine whether there are antibodies in the blood against Rh positive blood cells. If there are, the patient might become ill from jaundice, Bright's disease or anemia after transfusion of Rh positive blood. If the patient has not been sensitized, sensitization can be prevented.

"Of a group of 904 Rh-negative pregnant women, 46, or 5.08 per cent, displayed evidences of sensitization," according to the authors.

Among the byproducts of the operation of the laboratory the authors mention: (1) the maintenance of a supply of blood serum from Rh-sensitized patients; (2) the accumulation of a large list, available to all hospitals in the city, of Rh-negative men of all blood groups who are willing to serve as volunteer or professional donors in an emergency and (3) the application of Rh tests in medicolegal problems which involve disputed paternity.

### **National Cancer Institute Aids Medical Schools**

The National Cancer Institute is now prepared to give aid to medical schools for further development of courses in cancer for medical students, Dr. Thomas Parran, Surgeon General of the U. S. Public Health Service has announced. For the first time the National Cancer Institute received authority from the Congress this year to make grants-in-aid to

medical schools for this purpose. All of the grants made by the National Cancer Institute in the past have been for the support of research work on cancer.

This new activity of the National Cancer Institute is being inaugurated on the recommendation of the National Advisory Cancer Council which in turn based its recommendations on the results of a conference on cancer in the medical school curriculum held at the National Cancer Institute by a committee of medical educators.

Dr. Parran stated that the new program of aid to medical schools is designed to place greater emphasis upon the integration of cancer instruction in the total undergraduate curriculum. The deans of all medical schools have been advised that the National Advisory Cancer Council is prepared to receive applications for financial assistance in expanding their cancer teaching programs.

Grants will range from \$10,000 to \$25,000 per year depending upon the activities to be undertaken. Under provisions of the Appropriations Act that authorized this program, funds are available until spent. In order to assure continuity, the Surgeon General announces that funds have been set aside already for next year. It is anticipated that other agencies interested in promoting cancer control work will also give financial assistance to this program.

The Surgeon General added that plans are under way to inaugurate a similar program in dental schools on a somewhat smaller scale in the near future.

The committee of medical educators, whose report resulted in the new program is headed by Dr. Frank E. Adair, associate professor of clinical surgery, Cornell University School of Medicine, New York, and includes Drs. George M. Smith and Milton C. Winternitz of Yale University.

### Rhode Island Approves Prepaid Plan

The Rhode Island Medical Society through its House of Delegates has approved a program for voluntary prepaid nonoccupational surgical and obstetrical insurance which it plans to submit to all duly licensed insurance companies and the Blue Cross to increase the extent to which insurance against the cost of surgical care is made available to the people of that State.

The fundamental reason for the program, ac-

cording to President Arthur H. Ruggles, is to assist the person with low or moderate income. Therefore the Society is asking its members to subscribe to an agreement with it to provide complete surgical service for persons whose annual family income is under certain limits. These limits have been set for complete indemnity at \$2,000 for the individual and at \$3,000 for the family. A family income beyond these limits would mean that the surgical indemnity fee would be paid towards the physician's with the patient liable for an additional fee, if any.

In Rhode Island anesthesia and radiology are not included under the Blue Cross hospitalization contract. The committee setting up the prepaid medical care plan has agreed that radiology does not constitute a surgical benefit and, therefore, has not included it in the schedule of indemnities. On the other hand, it has included anesthesia even though its inclusion adds appreciably to the basic premium charge. Provision also is made in the schedule for payments to surgical assistants when the maximum amount set forth for the operative procedure exceeds \$49.00.

All insurance companies duly licensed in the State of Rhode Island may submit policy forms and these will be approved or disapproved in all respects except for the premium rates. If approved the companies will be authorized to use the statement "the benefits provided in this policy are accepted and approved by the Rhode Island Medical Society" on the policy and in advertising and promotional literature in connection therewith.

### San Francisco Physicians Resign

Eight hundred and eighty physicians of the San Francisco Medical Society decided to resign from the professional staff of the San Francisco Municipal Employee's Health System unless the Health Service Board would agree to reorganization of the Health Service System on a sound medical basis acceptable to the County Society and to the physicians serving the System.

Specifically, the Health Service System asked physicians on its professional staff to:

1. Limit and restrict the use of laboratory tests, x-ray examinations and normal diagnostic procedures and to substitute "routine examinations" for careful, scientific diagnosis. The diagnostic procedures thus restricted are essential safeguards for the



early detection of cancer, tuberculosis, pneumonia and other serious diseases.

2. Discourage patients with "minor ailments" from seeking medical treatment and advise them to use "home remedies."

3. Deny hospitalization to HSS members, except in emergency cases, without specific authorization of the medical director of HSS.

This compulsory health system is the only one of its type in the country.

### AMA Directory

At least two carloads of special light weight paper will be required for the new American Medical directory, a 3,000 page volume which normally is issued every two years. It is now almost five years since the 17th edition of the directory was published in 1942. The delay has been due to the shortage of clerical help and mechanical labor in the Chicago area as well as to the scarcity of paper.

The superintendent's office, which supervises printing production at headquarters, reports that the paper shortage existing for some time has presented one of the biggest problems in getting out the directory. Because of the shortage of compositors in the AMA printing department, composition work on the directory will probably have to be done outside of the AMA plant. Printing, however, barring unforeseen problems, may be done on the AMA presses.

It is hoped that compilation of names will be well under way shortly so that the 18th edition will be ready for delivery by at least the latter part of 1948. Since publication of the 1942 edition, information on 37,462 new physicians has been added to the files, and the names of 17,860 physicians who have died have been deleted.

### Number of Births First Quarter of 1947

In the first quarter of 1947 approximately 973,000 births were registered in the United States, according to preliminary estimates released recently by the National Office of Vital Statistics, U. S. Public Health Service, Federal Security Agency. This is 46.5 per cent more than the 664,000 births estimated to have been registered in the first three months of 1946, and it is 29 per cent more than the number recorded in the first quarter of 1943, the year which held the record for births until outstripped by 1946.

Deaths in this country are estimated to have

totaled 388,000 in the first three months of 1947. This is the same estimated number as that for the first quarter of 1946. In 1946 there was a mild epidemic of influenza and other respiratory infections that increased the number of deaths in January over the number recorded in non epidemic years. In 1947 the incidence of influenza increased in March and the provisional death rate reported for March was higher than for that month in any year since 1943. The death rate for this past March was 11.3 per thousand population, as compared with 11.7 for March 1943. For the first quarter of 1947 the death rate on a cumulative basis was 11.0 or 1 per cent less than the comparable rate of 11.1 deaths per 1,000 population (excluding the armed forces overseas) for the first quarter of 1946.

### CARE

UN and government reports from abroad predict that the coming winter will be even more severe than the last. Unknown thousands of Europe's undernourished, disease ridden millions failed to survive the last winter. Without help, thousands more will be doomed to die this winter.

Herbert Hoover has called CARE "the only sure and efficient way of sending packages to friends and relatives in Europe." Each of CARE's twelve different types of packages are guaranteed for delivery to anyone in fifteen European countries. They are sent by individuals or groups to friends, relatives or needy in Europe. If the giver does not know an actual person abroad, CARE packages can be sent to types of persons such as a displaced person, an orphan, a member of a religious group. A \$10 CARE food package contains 41,000 calories—enough food to supplement regular family rations for a month.

This Christmas, many Americans will want to share their good fortune with friends, relatives and the needy abroad. Address CARE, 50 Broad Street, New York 4, N. Y.

### New Associate Editor of Journal AMA

Dr. Morris Fishbein, editor of *The Journal of the American Medical Association*, has announced that Dr. Richard J. Plunkett has taken over his duties as associate editor of *The Journal*. Dr. Plunkett, who formerly was vice president and director of the Division of Health and Sanitation of the Institute of Inter-American Affairs in Washington, D. C., received his M.D. degree from Tufts Medical College in 1933 and his master's degree in public health from Harvard in 1939.

## MEDICINE AND THE VETERAN

### COMMITTEE ON MEDICAL CARE OF VETERANS

SAMUEL B. RENTSCH, Derby, *Chairman*

EGBERT M. ANDREWS, Hartford

NORTON CANFIELD, New Haven

JOSEPH N. D'ESOPPO, New Haven

### Chest X-ray Films

Veterans Administration now is the custodian of more than 53,000,000 Army chest x-rays films of World War II veterans, which it will use in its long range anti tuberculosis program.

The films, which include those made of each Army veteran at the time of induction and separation, comprise the largest single group of x-ray films in the world.

The films will assist VA in its study of tuberculosis among veterans and will also be available for determining eligibility of veterans for compensation.

Chest x-ray films of Navy and Marine Corps personnel will be retained by the Navy. Those of Coast Guard personnel are in possession of the Public Health Service.

To augment study of the x-ray films, VA has established a "central case register" of all World War II veterans who were discharged from the armed forces because of tuberculosis.

This register enables the out-patient tuberculosis clinics of VA regional offices to keep in close touch with each veteran who contracted TB while in the service. Combined with the information on the millions of x-ray films, the register will be of assistance in the long range study of the disease among the veteran population.

About 30,000 of these cases now are in the files. VA records show that about 23,000 veterans of World War II are drawing compensation for tuberculosis contracted in the service.

### VA Loses Interest In Deal With Massachusetts Blue Cross

Permitting the Blue Cross to contract with the Veterans Administration to provide hospital services for veterans was generally opposed recently before the insurance committee of the Massachusetts legislature. Senator Charles J. Innes, committee chairman announced that the regional office of

the VA, which favored the plan last year, has voiced opposition to it now, presumably because of the current difficulties of the Blue Cross.

Insurance Commr. Charles F. J. Harrington took a similar stand, saying, "Blue Cross problems are sufficiently acute so that it should solve them before taking on new ones." The American Legion also opposed the proposal, and no one favored it.

### Dr. Magnuson Succeeds Dr. Elliott Cutler

Appointment of Dr. Paul B. Magnuson, former professor of surgery and chairman of the Department of Bone and Joint Surgery at Northwestern University Medical School, Chicago, as acting chief of Veterans Administration Professional Services, was announced recently by VA.

Dr. Magnuson came to VA in November, 1945, on six months' leave from Northwestern and from his duties as attending surgeon at Passavant Memorial Hospital and senior consulting orthopedic surgeon at Wesley Memorial Hospital, to assist Dr. Paul R. Hawley, VA's chief medical director, in reorganizing medical care for veterans.

He has been with VA since as acting chief of the Research and Education Service.

As acting head of Professional Services, which includes general medicine and surgery, neuropsychiatry and the tuberculosis service, Dr. Magnuson succeeds the late Brig. Gen. Elliott C. Cutler, who died August 16, 1947.

Dr. Edward Harvey Cushing, former associate clinical professor of medicine at Western Reserve University, Cleveland, O., will succeed Dr. Magnuson as chief of the Research and Education Service.

Dr. Cushing, a veteran of both World Wars and a graduate of Harvard Medical School, has been associated with Dr. Magnuson since July 1946, as chief of the Education Division. He has done much work in connection with the establishment of VA's residency training program for doctors in many of its hospitals.



## Veterans Administration

Dr. William A. Hunt, professor of clinical psychology at Northwestern University, Chicago, has accepted appointment to Veterans Administration national advisory board on medical problems.

The board, appointed in compliance with Public Law 293, 79th Congress, acts in an advisory capacity to General Omar N. Bradley, administrator of Veterans Affairs, and Dr. Paul R. Hawley, chief of VA's Department of Medicine and Surgery, on overall policies concerning medical service to veterans. Dr. Charles W. Mayo, Mayo Clinic, Rochester, Minnesota, is chairman of the board.

Appointment of Dr. Arden Freer of Washington, D. C. (1211 Fern Street, N.W.) as deputy medical director of Veterans Administration, has been announced by Dr. Paul R. Hawley, VA's chief medical director.

Dr. Freer succeeds Dr. Robert C. Cook, who requested transfer to Colorado, where he will be manager of the VA hospital at Fort Logan.

Dr. Freer is a native of Neversink, N. Y. He obtained his education at New York University and Bellevue Hospital Medical College, graduating in 1913. He interned at Bellevue Hospital from 1913 to 1915. Dr. Freer is a fellow of the American College of Physicians, fellow and governor for the Army, American College of Chest Physicians; and fellow and former member of the House of Delegates (Army), American Medical Association. He also is a member of the Association of Military Surgeons and a diplomate of the American Board of Internal Medicine.

## Resale of Property

Veterans who have obtained G. I. loans for the purchase of homes, farms, or business enterprises, should have their attention called to the possibility of contingent liability in the event of resale, according to a memorandum issued by the Veterans Advisory Commission.

In cases where the buyer assumes or otherwise elects to pay any outstanding balance of the veterans indebtedness, a deficiency judgment may be obtained against the veteran following resale of the real property to secure payment of the original debt. A veteran relinquishing mortgaged property should attempt to settle his indebtedness in full and obtain release from his liability.

The government portion of the loan will be paid

to the lender prior to foreclosure in the majority of cases, according to the memorandum. Usually this insures the lender being "made whole" so that no claim will be made against the original veteran borrower. In such cases, the Veterans Administration stands subrogated to the lender to the extent of the government contribution. Any such claims paid by the VA on behalf of a veteran then constitute a debt to the United States Government. Under present policy, the Veterans Administration is not threatening legal action in such cases, the memorandum states.

## Health Services Bill for Northern Ireland

The British Parliament has received a proposed Act for a General Services Board for Northern Ireland similar to the one for England and Wales. As in the case of the latter two bills, this new one is designed to provide a free comprehensive health service. Regulations to be made later will define the personal medical services to be provided but the *British Medical Journal* informs us that no direction, positive or negative, of general practitioners is contemplated. Under the new bill any medical practitioner in Northern Ireland may practice where he chooses. Remuneration will be by capitation fee. A general practitioner's income from the Service will depend upon the number of persons who select him for a physician. In areas where the population is too small to provide adequate remuneration additional remuneration is authorized. An improvement of the English Act is found in the replacement of the numerous complicated penal clauses of the latter by a simple paragraph, that it shall be unlawful to sell the goodwill of the practice of the general practitioner who enters the Service. A statement of the penalties for such offenses is included.

## Chiropractic Supported by Federal Government

There are in existence today 17 schools of chiropractic where G.I.'s are receiving instruction with tuition for the same paid by the government. Even though many States have laws which do not permit chiropractors to practice, pressure may be brought to bear on these respective States to modify these laws in favor of the veteran because he is a veteran.

Keep your eyes open!

## OBITUARIES

### Robert Lester Waite, M.D.

1882 - 1947

Robert Lester Waite, the son of James N. and Maria Waite, was born in Hartford on September 13, 1882. He graduated from the Hartford High School in 1902 and from the Sheffield Scientific School of Yale University in 1905. He received his degree of M.D. from Johns Hopkins Medical School in 1909. He spent the year after graduation as assistant to Dr. James Bordley of Baltimore, and the following year he settled in Hartford where he practiced for thirty-six years, at first with his brother, Dr. Frank L. Waite. On the staff of the Hartford Hospital he was assistant ophthalmic surgeon and aural surgeon from 1910 to 1923, assistant ophthalmic surgeon from 1923 to 1927 and consulting ophthalmic surgeon from 1927 until the time of his death. He was a member of the American Medical Association, the Connecticut State Medical Society, the Hartford County Medical Association, and the Hartford Medical Society. Dr. Waite was forced to retire from practice in June, 1946 as the result of a coronary thrombosis that developed in October, 1945. He died on January 6, 1947.

Dr. Robert L. Waite was married on November 6, 1912 to Florence L. Burt of Windsor, Connecticut. Besides his wife he leaves one daughter, Barbara Francis Waite, now Mrs. John Hatch Thompson, of West Hartford and three grandsons, John Waite Thompson, Robert Waite Thompson and Frank Waite Thompson.

Dr. Waite was a well trained, capable physician, appreciated and respected by his associates. He endeared himself to his patients by his friendly and humane interest in them, his sympathetic understanding of their needs, and his conscientious medical care. Nothing connected with them was too trivial to engage his attention and concern. I recently happened upon this passage that seems to express his philosophy:

"I expect to pass through this world but once. Any good, therefore, that I can do, or any kindness that I can show to any fellow creature, let me do it now. Let me not defer or neglect it, for I shall not pass this way again."

E. Terry Smith, M.D.

### Paul Lange Phillips, M.D.

1904 - 1947

When Commander Paul Lange Phillips, Medical Corps, United States Naval Air Reserve, died in Norfolk, Virginia, on May 11, 1947, his large circle of colleagues, patients and friends mourned the passing of a brilliant scientist and a valued comrade. Possessed of a high degree of intellect and an indomitable spirit, he is remembered as one of those men whose life comes to an end too soon.

Only forty-three years old when he died, Paul Lange Phillips was born December 16, 1904, in Brooklyn, New York, the son of William Lincoln and Anna Lange Phillips.

From the beginning his avid intellectual curiosity combined with his imagination and inventive genius to make him an independent thinker destined to produce many scientific contributions. These qualities were evident throughout his lifetime, including the periods of his undergraduate studies and instructorship at Bowdoin College, Brunswick, Maine, and his medical student days at Cornell University College of Medicine, New York.

In 1932-33, he pursued his studies in neuropathology and clinical neurology in Berlin, Germany, after which he returned to this country to serve an internship and residency in neurology at Bellevue Hospital, New York City, in 1933-34. He went to the Institute of Living, Hartford, Connecticut, as a Resident in Psychiatry in July, 1934, remaining there as a member of the medical staff until October, 1940, when he entered the service of his country.

His stamina and quality of leadership helped to make his military career a brilliant one. Except for a brief period in 1946, he was on active duty with the United States Navy from 1940 until he died. He served at the Naval Air Station at Norfolk, at the Marine Air Corps Station at Parris Island, South Carolina, and aboard the aircraft carriers, Kasaan Bay and Wake Island. He also participated in the invasions of Luzon, Iwo Jima, and Okinawa.

Favored with a deep human understanding, Dr. Phillips was particularly fitted for his chosen field of neuropsychiatry. At the time he died he was



being pointed out in military circles as one of the rising young doctors in aviation medicine, while at the same time civilian neuropsychiatric practice still had not given up hope that he would return to its sphere to make his contribution there.

Those who were privileged to know Dr. Phillips found inspiration and pleasure in his great capacity to enjoy life, and found a source of ever increasing admiration in his courage in meeting life's many challenges.

His passing was most untimely and deeply mourned.

He is buried at Arlington National Cemetery, and is survived by his wife, Margaret Turner Phillips, and two sons, Karl Lange Phillips and Peter Turner Phillips.

C. Charles Burlingame, M.D.

### Clifton Mather Cooley, M.D.

1881 - 1947

Dr. Clifton Mather Cooley, an offspring of early settlers, was born in South Norwalk, July 31, 1881. Hard work characterized his life from the beginning and as a young boy he showed purpose and determination. This was evidenced by his finishing a four year school course in sixteen months; and he had to travel eighty-four miles a day to do it. He was strong and straight in stature and likewise in conduct of his life and work. After a year at New York University he entered Yale University Medical School from which he graduated in 1908. His friends and colleagues will recall his vivid accounts and accomplishments as resident physician and surgeon in New Haven Hospital for two years; and for the next two years as assistant superintendent in Worcester City Hospital and examining physician for that city, each of which jobs was enough for an ordinary man. Yet to this enterprising young physician of boundless energy, x-ray, then a baby in swaddling clothes, held great interest. Both in that hospital and in New Britain, where he came to practice in 1912, he started work in radiology. One may appropriately ask: How much did exposure to x-ray of those days have to do with his developing chronic lymphatic leukemia from which he suffered for twenty years, and which disease undoubtedly contributed to his demise on September 5, 1947? Unmindful of the hazards of the unknown and endeavoring to push ever forward the frontiers of knowledge and application of that knowledge to

alleviate human suffering, in death he paid the price of the pioneer.

During World War I, in addition to a busy practice and active surgical work at the hospital, he served his country on Draft and Appeal Boards and his city by caring for its school children. Undismayed and unretarded by illness, for many years he carried on an active practice, at the same time being physician to Civil Service, the Post Office, the F.B.I., Landers, Frary and Clark Manufacturing Company, an insurance examiner, and for the last five years of his life a medical examiner. For those twenty long years he bore his chronic illness with silence and fortitude, none but the intimate knowing about his condition. In spite of such a busy life he found time to be human, to show kindness and to give advice to those in need, and to spread cheer among his fellow men.

He was a member of his local, state, and national medical societies, of the First Baptist Church, and of Centennial Lodge, A. F. & A. M. He is survived by his wife, Ethel Stone Cooley, a son, Clifton M. Cooley, Jr., three grandchildren, and a countless number of patients who shared in his generosity. The ranks of the staff of New Britain General Hospital are thinned by the loss of one of its senior surgeons; and the Medical Society of New Britain has lost a fine physician, a friend and a credit to the profession. The community deeply senses its loss.

Philip J. Moorad, M.D.

### Sickness Statements For Rail Workers

Physicians throughout the nation are being asked to furnish medical evidence to substantiate the claims of railroad workers who may now draw cash sickness benefits under the Railroad Unemployment Insurance Act. The Railroad Retirement Board pointed out that unless an application is mailed not later than the seventh day after the first day of sickness claimed, it may not be received within the legal time limit for filing applications. As a result, the employee may lose one or more days' benefits. Doctors are asked either to return each completed Statement of Sickness to the patient, or mail it promptly to the office of the Board to which it is addressed.

## WOMAN'S AUXILIARY

### TO THE CONNECTICUT STATE MEDICAL SOCIETY

President, MRS. ROBERT J. COOK, New Haven

First Vice-President, MRS. CHARLES W. GOFF, West Hartford

Second Vice-President, MRS. JAMES DOUGLAS GOLD, Bridgeport

Recording Secretary, MRS. F. ERWIN TRACY, Middletown

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Treasurer, MRS. FRANK DiSTASIO, New Haven

## FEDERAL PROPAGANDA FOR THE WELFARE STATE

MARJORIE SHEARON, PH.D., *Washington, D. C.*

The Author. *Legislative Consultant, Washington, D. C.*

### ALLEGED JUSTIFICATION FOR THE WELFARE STATE

One of the basic issues in the 1948 Presidential campaign will be whether or not a Welfare State is to be established in this country. By a Welfare State I mean a form of central Government which would provide a wide range of cash, service, and other benefits to the entire population at public expense and which would control the people by "regulative interference." Justification for establishment of a Welfare State is based on the alleged need of the people for greater economic security, better nutrition, and sounder health than can be provided by the majority of the population through their own efforts. The more abundant life, it is claimed, can be obtained only through Federal intervention and the development of a national welfare program to protect the entire population from life's major hazards.

President Truman in announcing his legislative program on November 19, 1945, called upon Congress to enact a series of health and welfare laws. The legislation which has thus far been introduced into Congress to implement the Truman program would gradually transform our system of Government into a Welfare State which, for centralization of power and public revenues, would surpass the Communist State in Russia and the Socialist State in Great Britain.

The first step in creating such a planned or compulsory economy would be enactment of a Federal law for national social insurance either through piecemeal legislation or through a series of bills purportedly for the general welfare. The blueprint

for such legislation has already been presented to Congress in the Comprehensive Wagner-Murray-Dingell bill of 1943 (S1611 of the Seventy-eighth Congress) and in a similar, more grandiose omnibus bill in 1945 (S1050 of the Seventy-ninth Congress). This overall blueprint for comprehensive compulsory national social insurance should be kept in mind because it is the *sine qua non* of a Welfare State. The law *must* be comprehensive, it *must* be compulsory, and it *must* be national if the planned Welfare State is to be set up.

National social insurance, it must be remembered, is designed to do three things: raise revenues; control people; and redistribute wealth and income. Universal "health insurance," or more properly speaking, sickness insurance, is one of the control measures contemplated. The full extent of the plans for governmental regulative interference cannot be appreciated by studying piecemeal legislation such as the bills for medical care insurance, or maternal and child health, or cash sickness benefits. These isolated bills cannot be divorced from their context of omnibus compulsion. One must not lose sight of the long-time objectives while quarreling over the detailed provisions of separate bills.

The idea of social insurance is new in this country where, until the passage of the Social Security Act in 1935, our experience with compulsory insurance had been limited to State Workmen's Compensation Laws. The Social Security Act, outgrowth of the depression was hailed as a great humanitarian measure and was passed with the overwhelming approval of all political parties. Major emphasis was placed on old-age insurance because of its great popular appeal and seeming social justification. Unemployment insurance was almost equally popular as the country

*Presented at a meeting of Woman's Auxiliary to the Connecticut State Medical Society, Hartford, September 24, 1947*



emerged from the long siege of unemployment in the early thirties. The act likewise provided modest grants-in-aid for expanded public health services and for assistance to dependent children, the aged, and the blind. Few saw reason to fear or distrust a law providing Federal aid and even compulsion for social objectives seemingly so desirable.

Had we then seen the total scheme in the minds of the planners who pushed the Social Security Act through Congress and who a little earlier maneuvered us into the socialist dominated International Labor Organization, we might have paused before embarking on a program and accepting a set of principles so alien to our way of living and thinking. At that time we unwittingly accepted the basic tenets of collectivism as opposed to those of individualism.

#### REGULATIVE INTERFERENCE

The Social Security Act bears the label "made in Germany." Historically it goes back to Bismarck's legislative program for State Socialism and to the principles of social legislation later laid down by the International Labor Organization. To understand the *real*, rather than the *avowed*, purposes of the Social Security Act, one must turn to the objectives set forth by Bismarck and his economic adviser. According to Bismarck's plan announced in the 1880's, the State was gradually to assume ownership of banking, insurance, and communications and was to set up a system of State "insurance against sickness, incapacity, and old age." The hard-pressed German Chancellor proposed a new type of tax, a pay-roll tax, which, it was asserted, would serve the dual role of raising revenues and of bringing about the desired "regulative interference" with the lives of the people.

The "interference" was designed to bring under federal regulation the distribution of income and wealth as well as the purchasing power and living habits of the "lower classes." The latter form of "interference" was to be accomplished by administrative rules and regulations and by compulsion. Bismarck's economic adviser stated, "This two-sides policy of taxation I call social. The second side here advanced . . . is based, as concerns the mass of the population, the lower laboring classes, on the assumption that in the truest interests of the nation a guardianship may and must be exercised over the national consumption or even the application of income to personal purposes."

Bismarck's so-called "social" insurance laws were acclaimed as the "high-water mark of German State Socialism" sixty years ago. We should note well and never forget that they were a congeries of laws embracing political and economic devices rather than genuine social measures. The point has been well made that social insurance is neither social nor insurance. As a matter of fact, it merely provides an ingenious taxing system and a clever device for "regulative interference" by an all-powerful central Government.

The first national compulsory sickness insurance law was enacted in Germany in 1883. It not only became the model for similar laws in over 30 other countries but it also established the techniques of intrigue, misrepresentation, and dishonest propaganda which have marked the stormy path of compulsory legislation for over sixty years. Essentially the legislative pattern is as follows: bills are drafted by non-medical, Government "experts" in the Executive Departments which are seeking increased power. Bureaucratic economists and social planners do the drafting sometimes without legal advice. The medical profession is either by-passed entirely or consulted perfunctorily. Tax rates are decided upon and are as large as the traffic will bear. Authority is given to Government officials to draft rules and regulations for administering the program. The legislation is sold to the public, to the legislative body, and to labor by misrepresenting the objectives, the contemplated methods of administration, and the end results. In our day, freedom of choice is promised to physicians and patients alike; benefits are glowingly described; costs are scarcely mentioned. The scheme is publicized as an insurance law under which beneficiaries are entitled to completed medical care as a "right" by virtue of a token payment in the form of payroll taxes.

#### SOCIAL INSURANCE AS A "RIGHT"

It was Bismarck's idea that the so-called "lower classes" could be sold on the principle of "compulsion" and would submit to control by a powerful bureaucracy if they were promised certain benefits, including Government controlled medical care, as a "right." The bitter pill of compulsion was to be sugar coated with the false claim that workers would henceforth be "insured" by the State and would thus avoid the stigma of public charity.

The same sales talk is being used today in this country in selling the Wagner-Murray-Dingell bill

to Congress, to organized labor, to welfare groups, and to the public at large. Benefits are maximized, cost minimized. False promises are made by the bureaucrats who draft the legislation and by the lobbyists, inside and outside the Government, who are working to push the bills through Congress. Although our national income is nearing the annual rate of \$200 billion, arguments based on national needs when our income was one-fifth that amount are still being solemnly presented to Congress to justify Federal intervention in our daily lives. Senators, obviously misinformed about the legislation, are duped into lending their names and prestige in support of measures they would probably not support if they understood them. I do not doubt that President Truman himself has been sold a bill of goods without having any real appreciation of the long-range implications of parts of his legislative program.

Let me illustrate by giving a few examples of glaring misrepresentation in the publicity being disseminated by Federal officials and certain members of Congress who take their cue from those officials. Physicians are told that they will have a voice in deciding whether payment is to be made on the basis of capitation, fee-for-service, or salary. This myth was exploded when, under the penetrating cross-examination of Senator Donnell of Missouri at the health hearings this year, Michael M. Davis, one of the prime movers for the nationalization of medicine and chairman of one of the leading lobbying groups (the Committee for the Nation's Health), admitted that ultimately we would probably come to a capitation system if the Wagner-Murray-Dingell bill were enacted. Dr. Ernst P. Boas, chairman of the lobbying group known as The Physicians Forum, has likewise stated that "Insurance guaranteeing complete medical coverage cannot be set up, except at prohibitive cost, if the fee-for-service principle is retained."

It is thus perfectly clear that if the Wagner-Murray-Dingell bill is enacted into law our entire population of 140 million persons would ultimately be herded into a panel system like that which obtained for thirty-five years in Great Britain and which served as a precursor to the current plans for a salaried service. Patients would become Federal pawns, worth so much per head per year to the physicians on whose lists they appeared.

But this is by no means all that would happen if we had a system of sickness insurance in a Welfare

State. We are told by the Federal Security Administration that patients would be free to accept or reject the benefits of national social insurance and that physicians would be free to enter the system or to remain outside as they saw fit. The Federal officials who initiate such statements for the purpose of allaying fears of regimentation, *know* they are not speaking the truth. They *know* that a very considerable portion of the population would not be able to afford to pay the increased social security taxes of six per cent on payrolls together with the increased income taxes that would be required to finance the social insurance deficit and at the same time to pay for the private purchase of medical care. These same Federal officials *know* that members of the medical profession would ultimately be forced to sign contracts as Federally controlled insurance doctors unless they adopted a national policy of non cooperation as was done in Australia, is contemplated in Great Britain, and has been proposed in this country. If part of the profession were to sign up—and the debacle would start with the least capable physicians and with Communist sympathizers—there would be increasing difficulty for the remaining members of the profession to retain their freedom. The area of private practice would dwindle through a slow process of erosion. General practitioners would be squeezed out of private practice as competition from insurance practitioners increased. Specialists would find it impossible to reach a sufficiently large population from which to develop an adequate practice.

#### A SINGLE NATIONAL MEDICAL SERVICE

The International Labor Organization, which twenty years ago revised Bismarck's blueprint for socialized medicine and proposed the principles now being followed in this country by the authors of the Wagner-Murray-Dingell bill, stated in 1942 that:

" . . . once the whole employed population, wives and children included, is brought within the scope of compulsory sickness insurance, the great majority of doctors, dentists, nurses, and hospitals find themselves engaged in the insurance medical service, which squeezes out most of the private practice on the one hand, and most of the medical care hitherto given by the public assistance authorities on the other. *The next step to a single national service is a short one . . .*" (Emphasis mine.)

I will not here go into the question of deterioration of medical practice under compulsory insur-



ance. The subject has been fully aired many times. But I will say that if the Wagner-Murray-Dingell bill is enacted into law in the near future and the Federal officials who drafted the health and medical provisions retain their present positions, you may rest assured there will be little or no consultation with medical groups in the writing of the all important rules and regulations which would control not only all the health professions (physicians, dentists, nurses, technicians, etc.), but also hospitals, health centers, medical schools, and research centers.

The officials who wrote the Wagner-Murray-Dingell bill without consulting the professions which are concerned have designs of far broader scope than most persons realize. Federal sickness insurance alone would give them access to anywhere from *six to ten billion dollars a year* of tax funds. The total social security program when fully mature would take at least twenty per cent of the national income. If the Federal planners should succeed in their schemes they would induce Congress to transfer the tax collecting power from the Bureau of Internal Revenue to the Federal Security Agency. They would control the National Social Insurance Trust Fund even as Hitler did. To entrust such vast sums to a few Federal officials who are not elected representatives of the people and who, in the future as in the past, might act as though they were laws unto themselves, is, it seems to me, sheer folly. No bureaucrat and no political party should be able to control such funds and such power. These same officials would recommend to Congress ways in which the trust funds should be spent. They would determine capitation rates, hospital rates, and other scales of payment for services. While in advance it might be made to appear that the professions would be consulted about these matters, in reality, after the basic compulsory law was on the Federal statute books, pay scales would be determined by the amount in the health insurance fund and by the whims of Federal officials who were drafting the provisions for regulative interference.

#### POLITICAL PROMISES

The full intent of these plans has not been revealed by the nationalization propagandists. The public has been led to believe there would be no change in the present form of medical practice except that there would be no payment for services at the time of their receipt. The sales talk runs something like this: we in America are insurance minded. Let us pool our resources, everyone paying a little

into a health insurance fund, everyone receiving in return full medical care and health services for self and family. *It is so beautifully simple—and so damnable false.*

For instance, one of the promises repeatedly made by Senators Murray and Pepper is that everyone would have a complete physical examination every year. A little elementary arithmetic will show the fallacy of that promise. If 125,000 practicing physicians spent their full working time of 2,000 hours a year on physical examination for all the people, they would have less than 2 hours each to give to each person and there would not be a single physician available for anyone who was ill. The promises of the Wagner-Murray-Dingell bill and of the Federal propagandists are utterly fantastic. The bill, quite correctly, has been called a fraud on the American public. As a matter of fact, the Federal Government might well find itself in the position of the New Zealand Government which sold the people short by promising services it was not able to deliver. New Zealand finally said to its people, in effect: "If you can find a doctor who will treat you on the terms laid down by the social insurance law, we will foot the bill." But it was a case of first catch your doctor.

Now let us look at the methods employed for selling the idea of a comprehensive national social insurance law. There has been established in Washington a well organized propaganda machine inside the Federal Government. It is operated by Federal Security officials who openly flout Congress and daily break Federal laws by misusing Federal appropriations. They control the media for dissemination of information regarding social insurance, unmet health needs, cost of programs, etc. The Bureau of Research and Statistics in the Social Security Administration has prepared numerous reports for Senate committees. The central theme of these documents is that only through Federal "health" insurance can the health of the Nation be improved and adequate medical care be given to all the people. They have never explained by what legerdemain they expect to give to everyone all the promised services without running up the costs to prohibitive figures. Apparently they are following Hitler's advice about propaganda. He said:

"All effective propaganda has to limit itself only to a few points and use them like slogans. . . . It has to appeal forever and only to the masses. . . . The more modest, then, its scientific ballast

is, the more it exclusively considers the feeling of the masses, the more striking will be its success."

Thus the slogans of the Federal Government propaganda machine, which is financed exclusively, from tax funds, and of the cooperating non governmental lobbies are as follows: "*Health insurance is not socialized medicine.*" "*Health insurance must be compulsory.*" "*Medical services must be available as a right.*"

#### FEDERAL-COMMUNIST COLLABORATION

The Federal propagandists have worked closely with the two main private lobbying groups, the Physicians Forum, whose chairman is or was a member of eight Communist-front organizations, and the Committee for the Nation's Health, which is particularly active at Senate hearings. Both of these groups use the Communist International Workers Order as an outlet for publications. Recently the Committee for the Nation's Health prepared material for a film on "Medical Care Insurance," to be distributed by the IWO. The Social Security Administration, the Public Health Service, and the Farm Security Administration furnished pictures to the IWO for the same propaganda film strip. Publicity for the film appeared in the *Daily Worker* of June 2, 1947.

The International Workers Order is one of the strongest and most active Communist organizations in this country. Founded in 1930, it follows the Moscow line. An essential part of its program is the establishment in the United States of a comprehensive social insurance system along the lines laid down in the Communist International. The IWO has supported each of the Wagner-Murray-Dingell bills. The organization sent an admitted Communist to testify this summer in favor of S1320. The primary objective of the IWO is the overthrow of our form of Government and the establishment of a Communist State. This is the organization which is aiding in the propaganda for the Welfare State and which in turn is being aided by Federal officials.

This entire situation, as many of you know, is now under investigation by the Harness Subcommittee on Publicity and Propaganda. Hearings have been held in the House and one report has already been published. A large number of officials in four bureaus in the Federal Security Agency have been charged with misuse of Federal funds for the purpose of socializing medicine. The subcommittee voted unanimously to request Attorney General

Clark to investigate the lobbying activities of those officials who long have endeavored to foist upon the American people an alien system of national social insurance as a prelude to establishing a Welfare State under Federal control. The Department of Justice recently completed a preliminary study of the Harness hearings and charges. It was sufficiently impressed to refer the entire matter to the FBI which two weeks ago started its own investigation, attention being centered on the Bureau of Research and Statistics in the Social Security Administration.

#### MISSION TO JAPAN

During August Representative Harness called attention to the fact that some of the same Federal officials whose activities were even then under investigation were planning to fly to Japan to sell the Wagner-Murray-Dingell bill to the Japanese. The Harness subcommittee requested that the Social Security Mission to Japan be delayed pending the results of the investigation. Protests from all over the country were sent to the Secretary of War to the Federal Security Administrator, and to General MacArthur, urging that the Mission be held up. The AMA offered its professional services to make a bona fide study of the health and medical needs of Japan. Nothing could illustrate more clearly how hell-bent these Government officials are to do as they please, regardless of Federal laws and of the wishes of a Congressional committee, than the complete disregard they showed for requests to delay the Mission to Japan. The Mission departed on August 28. The four officials who went have long been associated with the leader of the nationalization movement in the United States. The Commissioner of Social Security, Arthur J. Altmeyer, together with other Federal officials, all of whom are under investigation by the FBI, plan to proceed to Japan a little later, at the taxpayers' expense. An omnibus national social insurance bill of the Wagner-Murray-Dingell type is to be ready for the Japanese Diet by October 1 with the aid of the members of the Mission to Japan. Compulsory legislation which our own Congress has refused to accept for this country may yet be foisted on the Japanese if our states do not intervene.

In the meantime the Harness subcommittee is continuing its skillful probe of the Federal Security Agency all through the summer. It has descended on the files of the Social Security Administration unearthing letters and other documents which demonstrate how closely the Bureau of Research



and Statistics worked with the newspaper *PM*, with lobbying groups, union officials, and the International Labor Organization.

These several investigations will not be completed until early in the next session of Congress. In addition, the Senate hearings on health legislation will be resumed in January. Isidore S. Falk, director of the Bureau of Research and Statistics, will be recalled to continue testifying on his activities as leader of the nationalization movement and as the most active Federal lobbyist for compulsory sickness insurance.

For the first time it seems likely that there will be brought into the open the full story of the effort of a handful of Federal officials to grab control of vast Federal trust funds and to establish a Welfare State in the United States. Until the activities of these officials are fully aired and the law has been invoked against them, there is small chance of any true cooperation between the States and the Federal Government in working out a genuine national health program.

The officials now under investigation have not inspired confidence; their reports have been discredited; the reliability of their interpretations of factual material has been challenged at the Senate hearings. Their integrity has been questioned. It is a matter of grave concern to every citizen when a Federal official fails to regard a public office as a public trust. It is a national calamity when that same official, driven by an overweening urge for power, endeavors surreptitiously to sell State Socialism to the Congress in the guise of legislation allegedly for the general welfare.

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### State Auxiliary Notes

A luncheon board meeting of the Woman's Auxiliary to the Connecticut State Medical Society was held at the home of Mrs. Robert J. Cook, president, on October 29, 1947.

Mr. Francis Russell, chairman of the Joint Committee of State Mental Hospitals, spoke to the board of directors on a one-day school for members of the Auxiliary. His talk was most interesting and his plan for showing how the Auxiliary can help in this worthy cause will be discussed with each County Auxiliary through the county presidents.

Study groups on Medical Legislation to be started in the State Board and branching to the counties

are under discussion. These groups will be conducted under the direction of Mrs. William Mac Shepard, State public relations chairman and Mrs. G. Gardiner Russell, State legislation chairman. Further details will be announced later.

The Board has delegated Mrs. Cook to appoint a committee to investigate the cost of a separate News Sheet to be printed at intervals by the Woman's Auxiliary to the Connecticut State Medical Society.

Mrs. Robert J. Cook and Mrs. James Douglas Gold will attend the President and Vice President Conference to be held in Chicago this month.

Mrs. William Mac Shepard has sent letters to the county presidents, outlining plans for a Speakers Bureau, also hoping that each county will plan to have a Health Day.

Mrs. James Douglas Gold again wishes to remind the membership of the date of the semi-annual meeting, December 4, 1947. Registration will be at 4:30 P. M. Business meeting 5-6 P. M. Social hour 6-7 P. M. Dinner at 7:00 P. M. Speaker, Louis H. Bauer, M.D., Hempstead, N. Y.

This is the fourth Christmas since the organization of the Woman's Auxiliary to the Connecticut State Medical Society. To those, whose efforts and interest have made it such a success, Mrs. Robert J. Cook, our president, says "Merry Christmas and Happy New Year."

#### FAIRFIELD COUNTY

The fall meeting of the Woman's Auxiliary to the Fairfield County Medical Association was held at the Algonquin Club in Bridgeport on October 28. Thirty-six members were present. Alphonse Perren, M.D., of Stamford spoke to the Auxiliary on "World Affairs." A White Elephant Sale netted about \$45 for the Laurel Heights Occupational Therapy Fund.

#### LITCHFIELD COUNTY

The Woman's Auxiliary to the Litchfield County Medical Association held a luncheon and meeting, October 15, at the Riverton Inn. Mrs. Winfield Wight of Thomaston presided. Miss B. J. Piper, director of the therapy at the Fairfield State Hospital, Newtown, was the guest speaker. The subject matter referred to the purpose of the State Hospital data pertaining to patient care, therapy condition, work, treatment, and recreational needs, of stimulation of community interest by way of boarding homes, work placements, volunteer associations,

contributions to activity fund and donations of all kinds.

#### MIDDLESEX COUNTY

A meeting of the Woman's Auxiliary to the Middlesex County Medical Association was held at Bengston-Wood Hall on October 20 with 24 members attending. The business meeting included reports from several committee chairmen and a discussion of projects to be undertaken by the Auxiliary during the year. The president, Mrs. Edgar C. Yerbury, then introduced the guest speaker, Mrs. Robert J. Cook of New Haven, president of the Woman's Auxiliary to the Connecticut State Medical Society. Mrs. Cook outlined the growth of the Auxiliary since its founding 4 years ago and discussed briefly several bills of interest to those concerned with the health of the nation. Mrs. Walter N. Nelson and Mrs. F. Erwin Tracy poured at the tea which followed the meeting.

#### NEW LONDON

Mrs. C. Tyson Hewes, presided at a Board meeting of the Woman's Auxiliary to the New London County Medical Association held at her home on October 22. At the meeting a publicity chairman was appointed to fill the unexpired term of Mrs. Harold W. Wellington. The appointment of a chairman for post war planning was made and also a new member added to the *Hygeia* committee. Plans were completed for the fall meeting.

#### HARTFORD COUNTY

The third fall meeting of the Woman's Auxiliary to the Hartford County Medical Association was held at the Hartford Golf Club on October 28. The business meeting was called to order by the president, Mrs. Paul W. Tisher, at 5 P. M. Specific points of interest were the acceptance of the revised constitution and by-laws; the appointments and elections to the nominating committee and the adoption of a Memorial Scholarship Fund.

A social hour preceded dinner, which was served at seven. Ninety members attended.

Mrs. Tisher welcomed the members and guests and extended greetings from Mrs. Robert J. Cook, State president, who was unable to be present.

Mrs. Nicholas A. Marinaro, designer of the Hartford County Woman's Auxiliary president's pin, presented the first pin to Mrs. Arthur B. Landry, first president, who in turn presented a pin to Mrs. Paul S. Phelps, the second president. A message of appreciation was expressed by each

past president. Mrs. Louis H. Gold, second vice-president and program chairman, introduced the speaker of the evening, Dr. Ethel J. Alpenfels, associate professor of sociology at New York University. Dr. Alpenfels is a noted writer and lecturer as well as a nationally known anthropologist. She has taught at Beloit College, the University of Wisconsin, University of Chicago, as well as New York University. She is at present consultant in anthropology for the Bureau for Intercultural Education. The title of Dr. Alpenfels address was: "Building Unity through Understanding."

Plans for the second concert for the benefit of the children's project have been completed to be held at the Town and County Club in Hartford. The artists participating in the program will be: Dr. and Mrs. Robert Buol, New Britain, duo-piano; Mrs. Grant Irving, West Hartford, soprano, accompanied by Mrs. John Roberts; Dr. Paul W. Tisher, New Britain, saxophone, accompanied by Mrs. C. Edwin Carlson, New Britain; Mrs. Peter Scafarello, West Hartford, violinist and Mrs. Edward H. Crosby, Hartford, piano.

A rummage sale will be held at the Masonic Hall, West Hartford, in February, the proceeds to be given to the Memorial Scholarship Fund. It is hoped that every member will help in this worthy project. Further details will be announced later. However, if you wish information, please call Mrs. Ralph T. Ogden—Hartford 3-4358.

#### WINDHAM COUNTY

A very interesting Fall meeting was held by the Woman's Auxiliary to the Windham County Medical Association at the Ben Grosvenor Inn at Pomfret on October 16 at 12:30 P. M. After luncheon. Dr. Neil Dayton of the Mansfield School spoke on "Mental Retardation and what it means to Connecticut." This was followed by a film, "A visit to the Mansfield School," in which the pupils were shown at work and play.

Mrs. William Mac Shepard presided at the business meeting in the absence of Mrs. Morton Arnold, president, who was in Chicago. Twelve members were present, three prospective members.

This organization has sent two station wagons full of books and magazines to the Norwich State Hospital for the use of the patients. One delivery from the Willimantic area and one from the Putnam area.

*Hygeia* is to be donated to ten libraries in this county by this organization.



November 7, 1947

CORRESPONDENCE

TREASURY DEPARTMENT  
Washington

October 30, 1947

To the Editor:

The National Publishers Association has informed us of the great public service which you have extended to the Savings Bonds campaign.

It is no secret to many of our well known industrialists, economists and financiers that this campaign is serving a vital purpose not only in the wise management of our national debt, but also in the strengthening of our free enterprise economy.

On behalf of the Treasury Department, please accept our deepest appreciation for your magnificent cooperation. We are truly grateful.

Cordially yours,  
Elihu E. Harris,  
Advertising Director

Stamford, Conn.,  
October 7, 1947

To the Editor:

Allusion is made to the note in the current issue of the State JOURNAL concerning the establishment of a Rheumatic Fever Program in New Haven. Down here in Stamford, we say congratulations and welcome. In this city, a Community Program for the Study and Control of Rheumatic Fever was set up in 1939. This comprised a diagnostic and advisory clinic at the Stamford Hospital, a Case Register for all known cases and since 1942, a convalescent home for cardiac children called Lionheart. The whole activity is sponsored by a group of public spirited citizens representing various welfare agencies, and organized as the Stamford Cardiac Aid. With the cooperation of all of the pediatricians hereabouts, they are doing a little heralded but much needed job. As a matter of record, I feel that their efforts should be called to the attention of your readers.

Yours truly,  
S. A. Rose, M.D.

To the Editor:

As a member of the Connecticut State Medical Society I wish to direct your attention to the recent circular mailed to members of the society by the Mutual Benefit Health & Accident Association of Omaha, Nebraska, likewise their advertisement in the CONNECTICUT STATE MEDICAL JOURNAL.

It was my unhappy experience to be insured by this company back in 1940, and due to circumstances beyond my control I became ill and was totally incapacitated from November 10, 1943, until April 29, 1947, during which time the aforementioned association continuously refused to recognize my claim, and in fact continued to collect premiums for several months after my claim was submitted, whereas all other companies waived theirs.

A study of their advertisement as well as their contract reveals very misleading statements which the Physicians and Surgeons of this State should scrutinize very carefully before purchasing a policy.

I wish therefore to protest quite strenuously against the unfair tactics employed by this company with reference to their tricky and confusing clauses which even a legal mind will find very difficult to comprehend, or for that matter even interpret.

I am frank to say that I am not convinced that this company's own interpretation of their policy is incorrect. I think the language of their policy is not clear and that it is susceptible to their own interpretation as it is to mine.

The average busy man, professional or otherwise, seldom delves into hidden tricky clauses because he generally assumes that the agent as well as the insurance company are trustworthy, especially if they are licensed to do business in our State with Hartford as the world insurance center. He pays his premiums regularly and in good faith expecting that same trust and good faith to be extended him should he need it.

In other words he buys protection against adversity and takes for granted that the terminology "Health & Accident" implies complete coverage against all forms of ill health as well as accidents, little suspecting that the company hides behind tricky clauses.

Hoping that you will extend me the courtesy of publishing this letter in the column reserved for

such in the State JOURNAL, so that the members of our society will fully comprehend the type of policy they purchase as well as the trustworthiness of the company that issues it,

I remain, cordially,  
Andrew F. Resnisky, M.D.

## 200 Medical and 50 Dental Internships Will Be Offered by Army in 1948

Two hundred medical and 50 dental internships will be offered by the Army in 1948 to be filled by recent medical and dental school graduates.

The internships will be for a period of one year of active duty. They will be rotating and will include the following services:

- (a) Medical Internships:
  - (1) Medicine
  - (2) Neuropsychiatry
  - (3) Pediatrics and Contagious Diseases
  - (4) Laboratory
  - (5) Obstetrics and Gynecology
  - (6) General Surgery
  - (7) Urology
  - (8) Orthopedic Surgery
  - (9) Ophthalmology and Otolaryngology
- (b) Dental Internships:
  - (1) X-ray and Oral Diagnosis
  - (2) Operative Dentistry
  - (3) Oral Surgery
  - (4) Periodontia
  - (5) Prosthetic Dentistry

Pay scales for interns as first lieutenants will be in accordance with existing regulations covering commissioned officer's pay and allowances. Credit for purpose of pay is given in accordance with length of military service. Subsistence and rental allowances are determined by the marital status of the intern; additional subsistence and rental pay is provided for officers who are married or have other dependents.

Qualifications required for application are:

### (a) Medical interns:

A male graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association, who is eligible for appointment as a medical officer in the Officers' Reserve Corps of the Army. Graduates of foreign schools are not eligible.

### (b) Dental Interns:

(1) Citizens of the United States; graduates of approved dental schools (now completing 4th year of dental training); not over 30 years of age on 1 July 1947; have made no agreement to accept an internship appointment in any other institution; and meet the physical standards for appointment in the Dental Corps of the Regular Army. (AR 40-105.)

There will also be 350 fully approved residencies for periods of one, two and three years, depending on the specialty desired and previous experience of candidate, in various Army General Hospitals in 1948 which will include:

- (a) Cardiology
- (b) Contagion and Tuberculosis
- (c) Dermatology and Syphilology
- (d) Internal Medicine
- (e) Pediatrics
- (f) Physical Medicine
- (g) Anesthesiology
- (h) Obstetrics and Gynecology
- (i) Ophthalmology
- (j) Orthopedic Surgery
- (k) Otolaryngology
- (l) Surgery
- (m) Thoracic Surgery
- (n) Urology
- (o) Neurology
- (p) Pathology
- (q) Psychiatry
- (r) Radiology

Qualifications required for application as residents are:

(a) Regular Army Medical officers or applicants for the Regular Army who are graduates of an approved medical school (a male graduate of a medical school approved by the Council on Medical Education and Hospitals of the American Medical Association, who is eligible for appointment as a medical officer in the Officers' Reserve Corps of the Army—graduates of foreign schools are not eligible) and have completed at least one year of rotating internship in a hospital approved by the Council on Medical Education and Hospitals of the American Medical Association may be appointed as assistant residents, resident or senior resident whichever is commensurate with their professional background.



## SPECIAL NOTICES

### MEETING OF SECTION ON ANESTHESIA

The next meeting of the Section on Anesthesia of the Connecticut State Medical Society will be held on Friday, December 12, at 8:00 P. M. in the Educational Building at St. Francis Hospital, 114 Woodland Street, Hartford. The following program will be presented:

1. The Anesthesia Study Commission—Dr. Mayer Saklad, director of anesthesiology, Rhode Island Hospital, Providence, Rhode Island.

Case Reports—Dr. Jean Dunham, Hartford Hospital, and Dr. Leopold Trifari, St. Francis Hospital, Hartford.

2. "Voluntary Prepaid Medical Insurance and the Anesthetist"—Dr. James R. Miller, president of the State Medical Society, member of the Board of Trustees, AMA.

Members are cordially invited to attend the evening session as well as the morning operating room clinics at Hartford Hospital, Mt. Sinai Hospital, and St. Francis Hospital.

### CONNECTICUT VA MEDICAL SOCIETY

December 4—Subject: "Dermatological aspects of Internal Medicine." By Dr. Neville Kirsch, dermatologist.

December 11—First annual dinner meeting of the Connecticut VA Medical Society to be held in New Haven. The guest speaker will be Dr. H. M. Marvin, associate professor of medicine, Yale University and cardiologist, Grace-New Haven Community Hospital. He will speak on "Recent advances in the field of heart diseases."

December 18—Irradiation therapy in Nose & Throat Diseases by Dr. Lewis Chester, attending otolaryngologist, Rocky Hill Hospital and associate otolaryngologist, Mt. Sinai Hospital, Hartford.

### NATIONAL GASTROENTEROLOGICAL ASSOCIATION 1948 AWARD CONTEST

The National Gastroenterological Association again takes pleasure in announcing its Annual Cash Prize Award Contest for 1948. One hundred dollars and a Certificate of Merit will be given for the best unpublished contribution on Gastroenterology or allied subjects. Certificates also will be awarded those physicians whose contributions are deemed worthy.

Contestants residing in the United States must be members of the American Medical Association. Those residing in foreign countries must be members of a similar organization in their own country. The winning contribution will be selected by a board of impartial judges and the award is to be made at the Annual Convention Banquet of the National Gastroenterological Association in June of 1948.

Certificates awarded to other physicians will be mailed to them. The decision of the judges will be final. The Association reserves the exclusive right of publishing the winning contribution, and those receiving certificates of merit, in its Official Publication, *Review of Gastroenterology*.

All entries for the 1948 prize should be limited to 5,000

words, be typewritten in English, prepared in manuscript form, submitted in five copies, accompanied by an entry letter, and must be received not later than April 1, 1948. Entries should be addressed to the National Gastroenterological Association, 1819 Broadway, New York 23, N. Y.

### EIGHTH ANNUAL CONGRESS ON INDUSTRIAL HEALTH

The Council on Industrial Health will hold its Eighth Annual Congress on Industrial Health in the Cleveland Auditorium, Cleveland, on January 5 and 6, 1948. These dates immediately precede the Interim Session of the American Medical Association, which will be held in the Auditorium on January 7 and 8. General practitioners supply a large part of the medical services which workers receive through industry, and they are cordially invited to attend these industrial health sessions. The program of the Congress is being constructed with general practitioners in mind and will include discussions of first aid and emergency services in industry, physical examinations, administrative practices, applied physiology, aviation medicine, radiation medicine and practical expositions of occupational disease management, traumatic surgery and rehabilitation. Since full use of medical services in industry depends on support from management and the worker, the essential relationships will be discussed. Industry needs medicine as a practical ally and to promote human relations. The Industrial Health Congresses are intended to further these objectives.

### EYE SPECIALISTS OF THE AMERICAS TO MEET IN HAVANA

Plans have been announced for the Third Pan American Congress of Ophthalmology, which is to be held in Havana, Cuba, January 4 to 10, 1948. It is anticipated that about 1,000 eye specialists will attend the sessions at the University of Havana School of Medicine.

A program of more than forty formal papers has been arranged, with speakers divided about equally between physicians of the Northern half of the hemisphere and those of the Latin American countries. Papers presented by English-speaking ophthalmologists are to be discussed by their colleagues who speak Spanish, Portuguese or French, and the papers in the Latin languages will be discussed by members of the English-speaking contingent. During the presentation of each paper, slides bearing resumes in one other language will be shown, in order to facilitate understanding by those who are unfamiliar with the language used by the speaker.

Topics on which the eye physicians will exchange information cover a wide range. They include operations for cataract, glaucoma and crossed eyes, parasites that attack the eyes, hazards to the eyes in industry, effects of high blood pressure, syphilis and certain tropical diseases on the eyes, tumors, sulfonamide and penicillin treatment, and diseases peculiar to high altitudes of such countries as Peru and Bolivia.

## OUR NEIGHBORS

### Maine

A nine member commission including three physicians has been appointed and approved by the Maine Legislature to study the need for a medical school in Maine. The appointment of this commission followed the rejection of legislation for appropriation of funds to finance such a school in conjunction with the University of Maine.

### Massachusetts

The Massachusetts General Hospital will, in the early part of December, join four sister hospitals in presenting "Medical Center Of The Air" programs over WNAC and the Yankee Network, under the auspices of the Yankee Network Institute.

The Medical Center series made its bow on the Yankee Network in April of this year with the following Greater Boston Hospitals cooperating: Peter Bent Brigham; Massachusetts Memorial Hospitals; Boston City; and Beth Israel. Since that original airing the Medical Center has won wide acclaim for the important, timely topics discussed in round table fashion by doctors from these institutions.

Programs are aired weekly over WNAC and The Yankee Net in New England and are under the direction of Mr. James S. Powers, director of the Yankee Network Institute.

### New York

The Long Island College of Medicine has been authorized by the State Board of Regents to confer the degree of Doctor of Medical Science.

Granville W. Larimore, M.D., formerly educational director of the American Cancer Society, is the first physician to be appointed as director of the Office of Public Health Education of New York State under a new regulation limiting the office to physicians.

Standard Oil Company of New Jersey has made a contribution of \$250,000 to the New York University-Bellevue Medical Center Fund to be allocated as follows: \$100,000 for the construction and initial equipment of laboratories in the Institute of Industrial Medicine; \$50,000 for clinical facilities

in the University Hospital; \$50,000 in support of the general program; and \$50,000 for the support of original research relating to the petroleum industry. The last amount will be given in equal annual installments over a period of five years, commencing in 1948. The medical center includes the Institute of Industrial Medicine in which all students at the New York University College of Medicine will receive some training in industrial medicine.

## NEWS

### *from County Associations*

#### Hartford

"Boston's First Medical Society" is the title of a paper by Stanley B. Weld, read before the Beaumont Club and published in the July issue of *The Yale Journal of Biology and Medicine*.

The Hartford County Medical Association held its One Hundred Fifty-fifth Semi-Annual Meeting at Indian Hill Country Club, Newington, on October 28.

There was an excellent turnout of members for the business meeting and the largest turnout in many years for the dinner—a total of 173. The members were entertained by Dr. LeMoyne Snyder of the Bureau of Investigation, State Police, Michigan, who gave us some interesting information on "Medicine and Homicide Investigation."

#### Litchfield

Heinz Markwald, M.D., of New Hartford, has been appointed health officer of Barkhamsted to succeed Homer Ashley, M.D., of Winsted.

#### Middlesex

The semi-annual meeting of the Middlesex County Medical Association was held on October 9 at the Edgewood Country Club. Routine reports and business were acted upon. Four new members were accepted into the Society. They are George Crawford, Old Saybrook; Thomas Carey, Clinton; Joseph Epstein, Portland; and Nina Toll, State Hospital, Middletown. Dr. Harris Schumacher gave the scientific paper of the evening choosing for his





## Ever wish you were Aladdin?

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topic "Indications For and Technique Of Sympathectomy." Following the formal meeting a delicious buffet supper was enjoyed by all present including the State officers. A social evening followed the supper.

On Tuesday, October 14, the Central Medical Association held its monthly meeting. Dr. Margaret Lennox gave a very interesting discussion on epilepsy.

The annual meeting of the medical staff of the Middlesex Hospital was held on October 8. Election of officers was held and resulted in Louis LaBella being reelected for president, F. Irwin Tracy for vice-president and Clair B. Crampton for secretary. Benjamin Roccopriore was elected to membership on the Medical Advisory Council as a representative of the attending and assistant staff. Dr. McLeod reported a forty per cent autopsy record and stated that henceforth reports from her department on deaths would be divided into inevitable and preventable and that the latter group would be presented for staff discussion.

The Tumor Clinic is having regular monthly follow up and diagnostic sessions which are being very well attended both by patients and physicians.

The weekly Wednesday morning clinics have been renewed after a summer omission. A list of the subjects and speakers is as follows:

October 1—Small Bowel Tumors with Dr. Vinci presiding.

October 15—Case Presentations of the Medical Ward Service with Dr. Roccopriore and staff presiding.

October 22—Infectious Mononucleosis with case presentations with Dr. McLeod presiding.

October 29—Inflammatory Lesions of the Large Bowel with surgical staff presiding.

### New Haven

While visiting at Choate School, Wallingford, on October 23, Randolph Reynolds of New Haven was stricken with a coronary thrombosis and died a few hours later.

William N. Winne, for nearly 50 years a practitioner in New Haven, died suddenly on October 30 at the age of 75 years.

H. Houston Merritt of Columbia University School of Medicine was the monthly speaker at the November meeting of the Waterbury Medical Society. His subject was Epilepsy.

Alex B. Timm, M.D., and Robert Weston, M.D., will act temporarily as health officers of Milford until such time as a new full time health officer is secured. The position was made vacant by the resignation of George B. Davis, M.D., who has become health officer of Middletown. Dr. Weston will take charge of child clinics and restaurant investigations which Dr. Davis has conducted while Dr. Timm will be in the office of the health office three hours daily to take charge of all the normal routine duties that Dr. Davis has carried on.

John C. Allen of New Haven is the first Connecticut physician to be admitted to membership on the American Board of Physical Medicine. This Board held its first meeting in Minneapolis this September.

At the semi-annual meeting of the New Haven County Medical Association held in Waterbury October 23, Theodore G. Klumpp, M.D., president of Winthrop-Stearns, Inc., was the guest speaker. Dr. Klumpp predicted that compulsory retirement by 1980 of all workers forty-five years of age or older was foreseen if the present archaic system in this country is maintained of "pensioning off faithful retainers" solely on the basis of calendar age.

Dr. Klumpp stated that the weight of our population is shifting toward the older group and that we cannot persist in dumping workers in the "old age boneyard" when they reach a fixed age. He warned of a severe economic dislocation ahead, citing statistics of age groups in this country to prove that by 1980 there would be a potential labor surplus of thirty million workers if the elderly were scrapped summarily.

"Today, 33.3 per cent of our population is over forty-five years of age," Dr. Klumpp said. "It has been conservatively estimated that we will have not less than 150 million people by 1980. This means that by that time there will be 81 million forty-five years and over.

"In the light of the all-time employment record of almost 60 million gainfully employed which has recently been attained, this means that in less than thirty-three years we shall have more individuals over forty-five than the total number employed at the present time."

Dr. Klumpp stated that he was not advocating that the normal aspirations of youth for advancement in society be frustrated in favor of retaining



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aged employees. But, he said, to attempt to strike a balance by eliminating all workers over a certain age is an unfair penalty on age and experience.

"In a refined and delicate way it is a perpetuation of the jungle law of the fang and claw, where the leaders of the pack survive only until the younger beasts grow fierce enough to eliminate them. In modern civilization we are less violent, but the end result is approximately the same."

Charges that advanced age were synonymous with over-conservatism and stultification of progress were termed "illogical generalizations" by the speaker.

"Certainly Bernard Baruch, seventy-seven years of age, Serge Koussevitsky, seventy-three, Arturo Toscanini, age eighty, Herbert Hoover, at seventy-three, and Nicholas Murray Butler, at eighty-five, are no obstacles in the path of progress. And neither Senator Pepper, Henry Wallace, nor Tommy Manville have become more conservative as they have grown older," he said.

One of the most important steps in solving the problem of old age versus youth in the matter of jobs, Dr. Klumpp continued, is the successive reduction in working hours for all workers rather than reducing more and more older workers to a state of parasitism. He predicted a thirty hour work week in industry in a generation.

To secure the maximum potential contributions from our population, thus assuring a smoothly run economic unit and a contented citizenry, Dr. Klumpp proposed the following recommendations be adopted by Federal, state, city governments and heads of industry.

Compulsory retirement on a calendar age basis be abandoned since physiological age is not the same as chronological age; retirement, like hiring, should be selective and based on fitness to do a given job; compulsory retirement should be based on the recommendation of a retirement board composed of medical and psychiatric members as well as administrative officials; opportunities for down grading in position and salary should be offered the aging worker, just as the young apprentice works himself up in skill; industry, governmental and private institutions must make a greater effort to employ partially disabled persons; institutions for the aged and disabled must be changed from asylums to modern institutions where every convenience and scientific development is available for their physical, mental and spiritual comfort.

## New London

The semi-annual meeting of the New London County Medical Association was held on Thursday, October 2, at the Uncas-on-Thames Sanatorium. The business meeting was held at 4:30 P. M. at which time routine business was transacted. At this time twelve new members were inducted and held the first reading of three prospective members. This was followed by a delicious dinner which was served by and at the Uncas Sanatorium and from the comments passed one must assume that the chef and all those assisting did themselves proud. Later at 8:30 P. M. the scientific session presented as the speaker of the evening Irad B. Hardy, M.D., assistant surgeon, Massachusetts General Hospital, Boston. His subject was "Venous Thrombosis." The paper was received with enthusiasm and interest, as well it might be for the speaker showed expert knowledge of his subject. An interesting discussion followed in which many took part.

## Tolland

Tolland County Medical Association held its semi-annual meeting on October 21 at the Olde Homestead Inn in Somers. The attendance was the largest in recent years.

Reports were given by State Society officers and visiting delegates. The speaker of the evening was Dr. Edward J. Whalen of Hartford, who gave a stimulating talk on "Problems of General Practice in Ear, Nose and Throat." Since Tolland County physicians are all general practitioners, this subject was of great interest to all.

A short business meeting followed the dinner. The problem of "district health" for Tolland County was informally discussed.

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## News from Yale University School of Medicine

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A Public Health Service grant of \$25,000 for the improvement of cancer teaching has been awarded Yale University School of Medicine and approved by the National Advisory Cancer Council.

Max Taffel, assistant professor of surgery, is the



# Experience is the Best Teacher

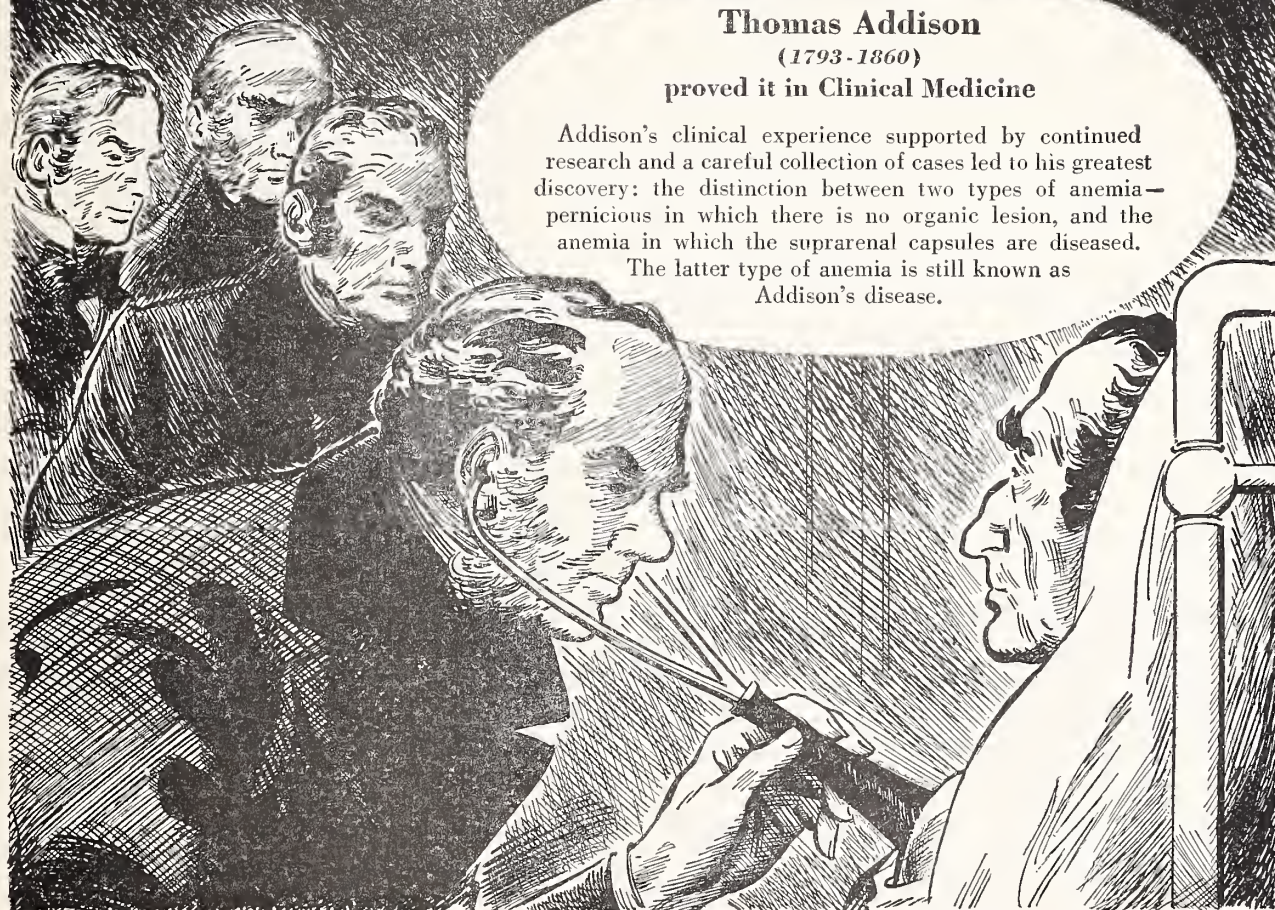
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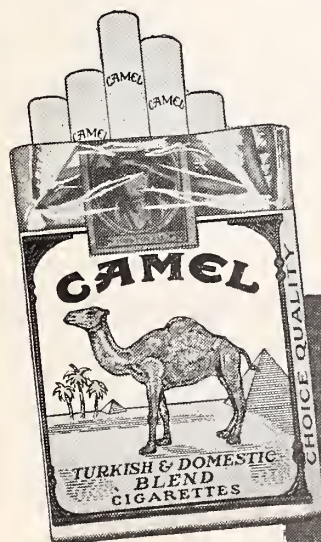


*Yes! And experience is the best teacher in smoking, too!*

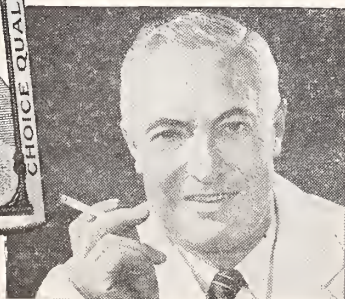
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author of an interesting contribution entitled "Experiences in the Treatment of Neoplastic Disease with Nitrogen Mustard," published in the July issue of *The Yale Journal of Biology and Medicine*.

Henry E. Sigerist has been appointed research associate in medical history at the Medical School. Dr. Sigerist, who recently retired as professor of medical history at Johns Hopkins University, is now in Switzerland, where he plans to write an eight volume history of medicine since the beginning of civilization. Yale said his appointment gives him full professorial rank with an indefinite leave of absence.

John F. Fulton, chairman of the department of physiology at the Yale School of Medicine, internationally prominent as a biographer and also as an investigator in the field of aviation medicine, delivered the five Heath Clark Lectures on the general subject "Aviation Medicine in its Preventive Aspects: An Historical Survey," in England during November. This lectureship is an endowment of the University of London.

Previous Heath Clark Lectures have included Sir George Newman, K.C.B., in 1931 on the "Rise of Preventive Medicine," Dr. William Bulloch, F.R.S., in 1937 on the "History of Bacteriology," and Prof. M. Greenwood in 1946 on "British Pioneers in Social Medicine—from Percival to Simon."

## Dr. Frank E. Wilson Appointed Red Cross Medical Administrator

Dr. Frank E. Wilson, Silver Spring, Md., has been appointed administrator of American Red Cross medical services to succeed the late Dr. Courtney Smith, killed in a plane crash last June.

Dr. Wilson has been deputy administrator of the services since joining the Red Cross staff June 15, 1946. As administrator, he will be responsible for ARC's disaster medical and nursing service and employees' health service.

Born January 9, 1909, in Knoxville, Tennessee, where he attended the public schools, Dr. Wilson is a graduate of the University of Tennessee College of Medicine and the University of North Carolina School of Public Health. After several years of private practice he served with the North Carolina health department.

In World War II, Dr. Wilson went on active duty as a first lieutenant in the Army Medical Corps in 1941, and, after both continental U. S. and overseas service, completed his military duty in 1945 as a colonel, commanding officer of the 807 Hospital Center.

From December, 1945, until his Red Cross service began, Dr. Wilson was director of public health for Cabarrus and Stanley counties, North Carolina, with headquarters in Concord.

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## NEW BOOKS IN REVIEW

### RYPINS' MEDICAL LICENSURE EXAMINATIONS.

(Sixth Edition.) Edited by Walter L. Bierring, M.D., F.A.C.P., M.R.C.P., Edin. (Hon.) Professor Emeritus, Theory and Practice of Medicine, College of Medicine, State University of Iowa; Secretary, Federation of State Medical Boards of the United States. Philadelphia: J. B. Lippincott Company. 1947. 690 pp. \$6.

Reviewed by JOHN D. BOOTH

Following the death of Harold Rypins, M.D., the original author of this worthwhile publication, Walter L. Bierring, M.D., undertook the editorship in its fifth edition and continues in the same capacity in this, the sixth edition of a book well known to most medical students and interns. Dr. Bierring has been assisted in his task by an imposing panel of medical educators representing medical schools in various sections of the country.

The general format is essentially the same as previous publications. The table of contents is divided into two parts: Part One, "Basic Medical Sciences," containing anatomy, physiology, chemistry, bacteriology, pathology and pharmacology; Part Two, the "Clinical Sciences," containing surgery, medicine, obstetrics and gynecology, hygiene and preventive medicine, and psychiatry. In the present edition one new subject, psychiatry, has been added to the subjects covered in previous volumes.

As in the past, the review of all subjects is presented in a most logical and orderly manner. To further prepare the student or graduate for State or National Board Examinations, at the end of each chapter there is presented a comprehensive list of questions, and in addition, blank pages are provided for personal memoranda.

This newest edition has been brought well up to date in the discussion of the antibiotics under the section of Bacteriology, and the sulfonamides are considered in the Pharmacological section.

In the chapter "The Philosophy of Examinations," Dr. Bierring states: "In the examination for licensure the object is not so much to test knowledge as it is to find if the candidate knows how to apply his knowledge to the diagnosis and treatment of disease." The so-called "trick" questions, questions involving highly technical procedures, should have little consideration by Medical Examining Boards, and Dr. Bierring quite properly recognizes this fundamental in presenting the material in this volume.

There can be little question but that this book should appeal to medical educators, particularly those involved in medical licensure, and for the medical student or graduate it provides a review of the medical sciences which should be of inestimable value in preparing him for State or National Board Examinations.

One might wish that the paper were of better quality, but presumably the publisher feels that by utilizing a somewhat cheaper grade it is possible to bring the cost down to a figure more within the range of the pocketbook of the average medical student.

PROCEEDINGS OF THE ELEVENTH ANNUAL CONVENTION OF THE NATIONAL GASTROENTEROLOGICAL ASSOCIATION. New York, June 19, 20, 21, 1946. Edited by Samuel Weiss, M.D., F.A.C.P., D.S.C. Reprinted from the *Review of Gastroenterology*, Volume 14, 1947. New York: Medical Authors' Publishing Co. 1947. \$2.50.

Reviewed by BENJAMIN V. WHITE

This small volume brings together four symposia: (1) on peptic ulcer, (2) on infectitious hepatitis, (3) on psychosomatic medicine, and (4) on gall bladder disease. The more recent developments included in these symposia are a discussion of protein hydrolyzates in the treatment of peptic ulcer, an analysis of the clinical features of infectious hepatitis, and an experimental study of changes in gastric function in response to varying life experiences. A recapitulation of this type is always of greater interest to those who attended the meeting than to the profession at large, but any one interested in obtaining a cross section of gastroenterology as of June 1946 should find the Proceedings helpful.

THE YEARS AFTER FIFTY. By Wingate M. Johnson, M.D., Professor of Clinical Medicine and Chief of Private Diagnostic Clinic, Bowman Gray School of Medicine of Wake Forest College, with a Foreword by Morris Fishbein, M.D., Editor, *Journal of the American Medical Association*. New York: Whittlesey House, McGraw-Hill Company, Inc. 1947. 146 pp. \$2.

Reviewed by O. J. BIZZOZERO

A welcome addition to the Whittlesey series. This is a remarkable little volume, well written, remarkably complete and surprisingly up to date. Dr. Johnson shows wisdom and common sense which comes with years of careful experience. He covers the social and philosophical aspects of old age briefly, but well. The material in the book is well edited. The chapters on Blood Pressure, Exercise, and Cancer could be read with profit by the profession, young and old.

To the individual over fifty, this little book will bring a true, accurate story, simply written and up to date. It should be read by the laity and physicians alike.

ADVANCES IN PEDIATRICS, VOLUME II. Editorial Board: S. Z. Levine, Cornell University Medical College, New York; Allan M. Butler, Harvard Medical School, Boston; L. Emmett Holt, Jr., New York University, College of Medicine, New York; A. Ashley Weech, University of Cincinnati, College of Medicine, Cincinnati. New York: Interscience Publishers, Inc. 1947. 409 pp. \$6.75.

Reviewed by FREDERICK P. ROGERS

In 1942 Adolph G. DeSanctes edited *Advances in Pediatrics*, Volume 1, which was a collection of monographs on timely pediatric subjects. Volume 2 follows the same pattern. The current editorial board has selected topics of unfailing interest to the pediatrician and to those interested in this field. The author of each monograph is nationally recognized in that field.

A review, therefore, of such a book would be of little value without listing the subject matter and authors.

1. Etiology of Congenital Malformations. Joseph Warkany, Cincinnati, Ohio.
2. Acute Infectious Lymphocytosis. Carl H. Smith, New York, N. Y.
3. Role of Fluorine in Prevention and Treatment of Dental Caries. H. Trendley Dean, Bethesda, Maryland.
4. The Treatment of Purulent Meningitides. Hattie E. Alexander, New York, N. Y.
5. Chemotherapy: Penicillin, Sulfonamides, Streptomycin, and Tyrothricin. Paul Gyorgy and Henry F. Lee, Philadelphia, Pa.
6. Atypical Pneumonia. John H. Dingle, Cleveland, Ohio.
7. Endocrine and Other Factors Determining the Growth of Children. Nathan B. Talbot and Edna H. Sobel, Boston, Mass.
8. Virus Diarrhea. Katharine Dodd, Cincinnati, Ohio.
9. Prematurity. Harry H. Gordon, New York, N. Y.
10. The Genesis of Physiologic Hyperbilirubinemia. A. A. Weech, Cincinnati, Ohio.
11. Prevention of Recurrences of Rheumatic Fever. Ann G. Kuttner, Irvington, N. Y.

In such a galaxy of topics and talents, one would be hard pressed to pick the most outstanding. The reviewer found the monographs on Congenital Deformities, Endocrine Factors in Growth, Prematurity, and Rheumatic Fever to be exceptionally well written and very informative.

The book is of importance to pediatricians. It can also be highly recommended to general practitioners who are desirous of keeping abreast of pediatric trends as well as specialists who may desire an understanding of the early stages of some of the disorders of adult patients which may have had their inception in childhood.

1947 YEAR BOOK OF RADIOLOGY. By Charles A. Waters, M.D., Assistant Professor of Roentgenology, Johns Hopkins University School of Medicine, and Ira I. Kaplan, M.D., Director Radiation Therapy Department, Bellevue Hospital, New York City. Chicago: The Year Book Publishers, Inc. 1947. 416 pp. 287 illustrations. \$5.50.

Reviewed by WENDELL C. HALL

The 1947 Year Book of Radiology, as in previous years, is divided almost equally between diagnosis and therapy with a total of 310 articles reviewed. These contributions were selected from 76 scientific publications of the U. S. A. and 14 other countries. A larger number of articles than usual from the European literature are included in this volume, with a return to more normal world conditions following the war.

The therapeutic section contains over a dozen timely articles on nuclear energy, some of which include the medical use of radioactive isotopes. This section also contains 2 articles on nitrogen mustards and their use in neoplastic diseases. Articles among others of special interest in the therapeutic section are those on venous catheterization of the heart, roentgen findings in acute pancreatitis, and nephrography.

The usual high standards of the Year Book of Radiology have been maintained in the 1947 issue.











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